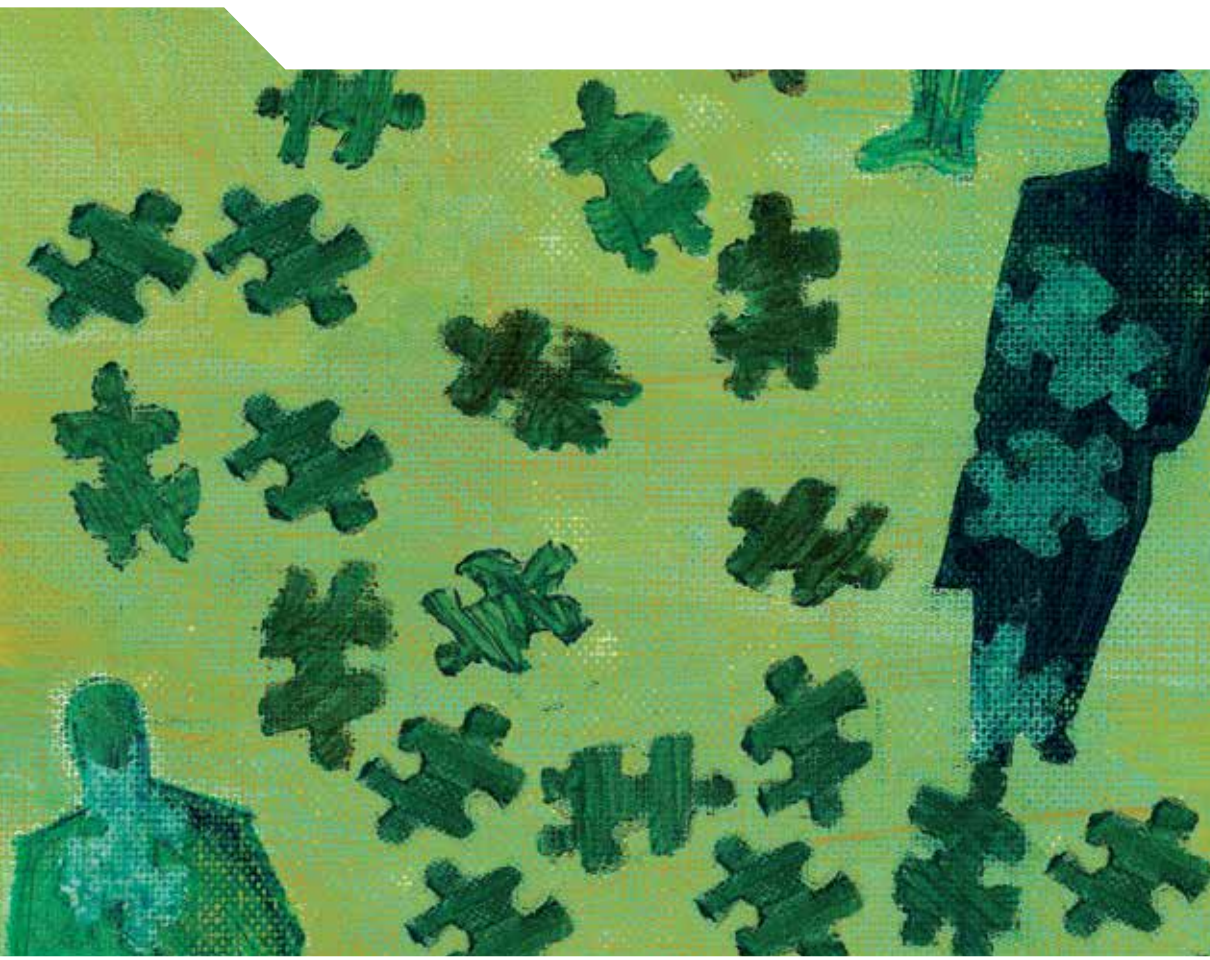
Mental Health and Work

AUSTRIA



OECD

Mental Health and Work: Austria



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Foreword

The mental health of the working-age population is becoming a key issue in labour market and social policies in many OECD countries. It is an issue that has been neglected for too long despite the high – and growing – cost of poor mental health to people and society at large. Increasingly, OECD governments recognise that policy has a major role to play in improving the employment opportunities of the mentally unwell – particularly among the young. Policies should seek to support employees who struggle in their jobs and help them avoid long-term sickness and disability caused by mental disorder.

A first OECD report on this subject – *Sick on the Job? Myths and Realities about Mental Health and Work*, published in January 2012 – identified OECD countries' main policy challenges by broadening the evidence base and questioning some of the myths that surround the links between mental ill-health and work.

This report on Austria is one in a series of reports that looks at how selected OECD countries address those policy challenges. It covers issues such as the transition from education to employment, the workplace, employment services for jobseekers, the drift into permanent disability and the capacity of the health system.

The other reports in this series consider the situations in Australia, Belgium, Denmark, the Netherlands, Norway, Sweden, Switzerland and the United Kingdom. Together, all nine endeavour to deepen the evidence on good mental health and work policy. They also contain a series of detailed country-specific policy recommendations.

This review was carried out by OECD's Directorate for Employment, Labour and Social Affairs. Christopher Prinz (OECD) and Niklas Baer (Psychiatric Service of Basel Landschaft) prepared the report. Dana Blumin and Maxime Ladaique did the statistical work, Natalie Corry and Gabriela Bejan provided project assistance, and Ken Kincaid edited the report. Special thanks go to Bernhard Mader for compilations based on the Work Climate Index and to Gerhard Buczolich, the project co-ordinator in Austria. The report also includes comments from a number of Austrian ministries and authorities.

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Acronyms and abbreviations

AGG	*Arbeit- und Gesundheit-Gesetz* (Work and Health Act)
AKI	*Österreichischer Arbeitsklima Index* (Austrian Work Climate Index)
AschG	*ArbeitnehmerInnenschutzgesetz* (Labour Protection Act)
AUVA	*Allgemeine Unfallversicherungsanstalt* (Austrian Workers' Compensation Board)
BMS	*Bedarfsorientierte Mindestsicherung* (Social Assistance)
C4C	Check for Chances
ECTS	European Credit Transfer System
ELGA	Electronic health record
ESENER	European Survey of Enterprises on New and Emerging Risks
EU	European Union
EU-OSHA	European Agency for Safety and Health at Work
EUR	Euro
EWCS	European Working Conditions Survey
GAF	General Assessment of Functioning
GDP	Gross Domestic Product
GP	General practitioner
ICD	International Classification of Diseases
ISCED	International Standard Classification of Education
NEET	Not in employment or in education or in training
PES	Public employment service (*Arbeitsmarktservice*)
PIA	Pension Insurance Authority (*Pensionsversicherungsanstalt*)
SF36	Short Form (36) Health Survey
SHARE	Survey on Health, Ageing and Retirement
SME	Small and medium-sized enterprise
TALIS	Teaching and Learning International Survey

Executive summary

Throughout the OECD, there is growing recognition that mental health is a major issue in social and labour market policy. Mental illness exacts a heavy price on people, employers, and the economy at large, affecting well-being and employment, and causing substantial productivity losses.

Austria has seen a rapid increase over the past 20 years in sickness absences and disability benefit claims attributable to mental disorders. Overall benefit dependency among the working-age population is high, with many claimants of all types of benefits, including unemployment benefit, reporting mental health problems.

Austria has a strong labour market, an easily accessible health care system, and a broad range of support services, all of which should yield fine opportunities for improving the labour market inclusion of the mentally unwell. However, the federal government's scope for developing coherent occupational health policies is curtailed by the structural and organisational fragmentation of responsibilities – with the nine regions having a strong say in health and education policies and the social insurance institutions being highly autonomous.

Successful reform requires that the wide range of institutions responsible for policy implementation co-ordinate closely. The 2013 disability benefit reform has considerable potential, for example. What it needs, though, is rigorous implementation accompanied by mutual knowledge-building and strong collaboration between the main institutions involved.

Further changes are also called for. The strong focus on prevention and health promotion in the workplace does not acknowledge employees' or employers' need for support. Mental health treatment is fragmented and the provision of care too far-removed from the labour market and the patients' workplaces.

The OECD recommends that Austrian policy makers:

- Implement the 2013 disability benefit reform rigorously for workers of all ages. There should be firm intervention in the periods they are receiving payments under the two new benefit schemes (rehabilitation and retraining). The reform should be extended to the entire labour force.
- Improve the competencies of the public employment service so that it can attend to clients who suffer from poor mental health. Free up the necessary case management time.
- Make sickness benefit payments part of an active system to foster a quick return to work by adjusting regulations accordingly and equipping the health insurance system with tools and competent staff to monitor risk groups and support doctors and patients.
- Develop workplace-related policies and interventions to support employers in retaining mentally unwell workers and further strengthen *fit2work* as an easily accessible active support service that has close links to other systems.
- Shift resources to increase mental health care to adequate levels, especially in outpatient and primary care, child psychiatry, and the provision for rural areas. Improve the continuity of care.
- Reorient education resources to increase qualified professional support for teachers and students, and ensure that teachers have a good grounding in mental-health knowledge and are well supervised.

Assessment and recommendations

Poor mental health costs the Austrian economy dear – 3.6% of GDP through lost labour productivity, increased health care expenditure, and social spending on people temporarily or permanently out of work. While the Austrian labour market is in good shape and was comparatively little affected by the recent economic downturn, at least initially, the mentally unwell underperform in the job market. Their unemployment rate is almost thrice the national average and their employment rates are lower.

Moreover, Austria has seen a steep rise in benefit granted for reasons of mental ill-health: from 10% of all disability benefits in the mid-1990s to over 35% in 2013, with wide differences by gender, occupation and region. In fact, benefit dependency generally in Austria remains high, with 20% of the working-age population receiving an allowance. People with a mental disorder are overrepresented in all benefit schemes, including unemployment. And even when they do have jobs, they often struggle at work – hence sickness absences that are more frequent and longer than among employees with no mental health concerns, and more frequent underperformance in the job. Finally, the average retirement age in Austria continues to be low, partly because of the widespread use of the disability route to early retirement, although the practice has shown signs of easing up in the past two years.

Austria boasts a number of labour and welfare strong points:

- a strong labour market
- a stringently managed, stable benefit system
- a comprehensive, easily accessible health care system
- a broad, and broadening, range of school support services
- a well-developed occupational medicine
- a large number of rehabilitative services
- a well-functioning employment service.

The structural fragmentation of systems and responsibilities, however, restricts the federal government's scope for developing coherent occupational health policies. Factors contributing to such fragmentation are the pronounced regional devolution of health and education policies, the highly autonomous and regionally structured branches of social security, and the important role of the social partners. A lack of data on and research into the links between work and mental ill-health compounds matters.

Rigorous implementation of the disability benefit reform is critical

The 2013 disability benefit reform, currently being implemented, has considerable potential for integrating more fully into the labour market people with chronic health problems who still have the capacity to work. The abolition of ineffective measures – like temporary disability benefit – and the restriction of disability benefits to people permanently unable to work should intensify activation and the provision of return-to-work support for the mentally unwell. The reform has also introduced two new types of benefit: a rehabilitation allowance which is paid by health insurance providers and retraining benefit, administered by the public employment service (PES).

The success of the reform hinges entirely on its rigorous implementation. Even then, however, it could fail unless it also addresses certain structural issues, chief among which is the critical need to improve the interface between the different stakeholder institutions. The Pension Insurance Authority (PIA) and the PES must collaborate and communicate better over assessments and retraining, as will the health insurance bodies and the PIA with regard to medical treatment and rehabilitation. What is required is a case management approach across institutions where a single authority – maybe the PES – is in charge of labour market integration.

As regards the new rehabilitation benefit, it needs to go hand-in-hand with new forms of monitoring, activation and intervention. The health insurance providers, which pay out benefit payments, have no real track record of helping people return to work. Moreover, sickness benefits no longer have a formal time limit, even though eligibility is to be reassessed regularly under the terms of the disability benefit reform. Without strong return-to-work action, open-ended sickness benefits could easily lead to higher numbers of disability benefit claims.

In addition, the important role conferred on the PES by the new retraining benefit requires PES caseworkers to show better understanding of the needs of jobseekers who suffer from chronic health conditions, particularly common mental disorders. Retraining schemes will be open only to jobseekers with good prospects of subsequent labour market

reintegration – something that may be difficult to predict for claimants with mental health problems.

The PES will have to broaden its traditional focus on finding jobs for job-ready jobseekers and design new instruments and processes if it is to be equal to the tasks of early identification, intervention and rehabilitation. Local employment agencies are poorly equipped and resourced for coping with their clients' mental health issues. They will have to strengthen their connections with health insurance providers' rehabilitation centres, the PIA and the health system in general.

Early intervention is critical to preventing unnecessary disability benefit claims, of which long-term sickness absence is a strong predictor. The need for early intervention makes health insurance a more important player than currently acknowledged in Austria's social insurance system. The recently implemented fit2work service for workers who have been on sick leave for upward of 40 days is a step in the right direction. Its ability to assist employers and provide psychological therapy for workers is critical. Support for employers and intervention early in sick leave – or even before a worker takes it – must be further expanded. For that to happen, the Austrian practice of employers and employees not discussing sickness matters will have to be revisited.

Better balanced workplace interventions are necessary

The workplace is the ideal place to tackle the increase in sickness absences and disability benefit claims for reasons of poor mental health. Public awareness of the issue has risen in recent years and the Labour Protection Act has accordingly broadened its scope to strengthen occupational medicine and support the use of occupational psychologists. All this has been achieved within a short period of time and through close collaboration between the social partners, social insurance providers and the authorities.

The shared aim of all involved parties seems to be to improve working conditions and minimise the health damage caused by work. However, general prevention and health promotion activities can be no substitute for action to support employers contending with mentally ill employees. Austria ranks second-highest in Europe, according to the European Working Conditions Survey, when it comes to the share of mentally unwell workers present in the workplace but whose poor health lessens their productivity.

Supporting employers more effectively, especially in underserved small and medium-sized enterprises (SMEs), calls for:

- further intensification of fit2work's employer focus
- a greater role for occupational doctors and psychologists
- a more extensive knowledge base within the Accident Insurance Authority, which is still oriented towards workplace accidents and is SMEs' main partner in occupational health and safety.

In Austria, the sickness absence rates of employees with a mental health condition are significantly above the OECD average. In addition, the share of those caused by mental disorders has increased substantially since the mid-1990s. Yet the legislation governing sick leave is restrictive and ineffectual, and the social partners have not yet managed to agree on procedures which would allow effective sickness absence monitoring and back-to-work intervention. Confidentiality is a high priority, ruling out contact between employers and sick-listed employees. Nor is there such a thing in Austria as partial sick leave that incorporates a stepwise back-to-work process. The wait-and-see culture is dominant in enterprises, leaving little or no room for contact between employers or case managers and treating physicians. The principle of "first cure, then work" minimises the success of return-to-work intervention, particularly as employees grow into their role as a sick person and develop avoidant behaviour.

Mental health care is variable and far removed from the workplace

In order to help psychologically unwell employees keep their jobs or re-enter the labour market, the health services must be responsive to the symptoms and consequences specific to mental health disorders – their early onset and enduring course, the frequent co-morbidity and lack of insight, and the stigma which attaches to them in the workplace. Health services should be able to:

- intervene early and sustain support
- offer an integrated provision of varying intensity that brings together inpatient and outpatient care and specialised and generalist treatment
- integrate psychiatric and physical treatment to tackle comorbidity
- intervene actively in difficult situations in the workplace to mediate between patients and employers.

There is some evidence that mental health services in Austria do not score so well on any of the four points for regional and structural reasons.

Around half of all psychiatrists work in the capital, while rural areas are often underserved. Responsibility for inpatient care is scattered across the different regional authorities, while health insurance providers manage private practitioners and outpatient care, and PIA handles medical rehabilitation. There are no systemic links or referral routes between those components of the system, which results in uncoordinated treatment courses. And with general practitioners (GPs) having no gate-keeping function, there is no-one to steer patients towards the right mental health care providers.

Furthermore, resources are poorly distributed. While Austria has the second highest proportion of physical disease specialists in the OECD and boasts many expensive hospital beds, the ratio of psychiatrists to the population is below the OECD average. Outpatient mental health care is dogged by lengthy waiting times and restricted choice of treatment provider. There is limited capacity in child and adolescent mental health care and, unsurprisingly, psychiatric treatment focuses on diagnostics and medication, not therapy.

Psychotherapy is under-subsidised by health insurance – the annual capped quota is too low and used up long before the end of the calendar year. Criteria for determining who is entitled to subsidised psychotherapy vary by region and generally favour patients with severe illness. Most people with work problems related to mild-to-moderate mental disorders can therefore receive psychotherapy only at their own expense. The fit2work service is an attempt to plug some of that gap by providing quick, free access to counselling and therapy.

The potential of trained GPs is not fully exploited. To make up for the lack of psychiatry and psychiatric rehabilitation in general medical training, the Austrian Medical Association has created a system of further education, the so-called "PSY Diploma" that trains GPs to provide psychotherapy. In practice, however, GPs generally intervene only in a brief one-off manner.

Most people with mental health problems are seen by a GP, but those problems often go unaddressed. GPs should also be empowered to discuss work with their patients and to communicate with their patients' line managers – in other words, support supervisors with the right information about how to behave with sick employees and adapt the workplace accordingly. GPs should be trained, too, to draft sickness absence certificates geared to helping patients back to work. And health insurance should reimburse GPs' workplace-oriented counselling.

More robust support for vulnerable students and their teachers

The education system has an important role to play in early identifying mentally unwell young people early and bringing support to bear. Little is known in Austria about how young people with mental health problems fare in the education system and the labour market transition, because such problems are not identified in any ordered way. Austria has a range of support in place to help schools and teachers, such as psychopedagogues, school social workers, school psychologists, youth coaches and external school doctors. However, support services taken as a whole are still insufficient and, although they are constantly expanding, Austria ranks poorly in the OECD when it comes to professionals able to dispense pedagogical support. School leaders increasingly call for more such support. There is also a need for better co-ordination and experts permanently on site in schools who can act as case managers. The inadequate interface between schools and the health care system also needs strengthening to make sure that pupils who need mental health treatment get it.

Poor education outcomes lead to poor labour market outcomes. Helping young people to achieve levels of attainment that match their cognitive abilities is critical: those who complete school or an apprenticeship have a much better chance of finding a job. In that respect, a recently implemented national scheme showed good results in its trial phase and has now been expanded nationwide. It is the Youth Coaching scheme, a three-step counselling process to pre-empt early school leaving that kicks in when teachers detect signs early. The recent shift to greater use of case management – a characteristic of the work of youth coaches – should be continued. Social, behavioural and mental health problems are so multifaceted that universal approaches are of little help. It is important to address multidisciplinary problems with equally multidisciplinary solutions.

Young people with mental health conditions are among those who struggle most to find work. Since the beginning of the Great Recession, the situation has deteriorated to the point where youth unemployment is now almost 2.5 times as high as among adults. There has to be a greater effort, especially by the PES, to help young people with poor mental health who do not finish school to improve their skills (by providing non-classroom training) and secure a foothold in the labour market. Apprentice Coaching, a scheme similar to Youth Coaching, should be widened to the whole country, with the PES a driving force.

OECD recommendations for Austrian policy on mental health and work

Key policy challenges	Policy recommendations
1. The disability benefit system has some features that prevent people with mental ill health from being better integrated in the labour market	• Address the rise in disability benefit by preventing claims and rejections through early intervention, improved assessments, equality of access, and greater research-based knowledge. • Rigorously implement the 2013 disability benefit reform to ensure flexible support that helps people stay in or return to work and do not just stay on benefit with a different name. • Rapidly expand recent changes to the entire labour force regardless of age and including farmers and civil servants.
2. Health insurance and the public employment service (PES) are not doing enough to improve labour market outcomes for mentally unwell workers	• Equip health insurance providers with the tools and competent staff for monitoring risk groups and supporting doctors and patients, so turning sickness benefit into a return-to-work instrument. • Rapidly develop the ability of the PES to attend to clients with health-related work barriers who are likely to grow in number in the wake of recent benefit reforms. • Modify PES procedures to ensure that it serves those clients adequately with more counselling and case-management time.
3. Workplace-related policies fail to address productivity losses and sickness absences caused by mental ill-health	• Help employers to retain mentally unwell workers through support that includes fit2work's services and improve the ability of occupational medicine to address mental health issues. • Tackle rising sickness absence through systematic employer monitoring of sick-listed workers, improved health insurance competencies, and the use of partial sick leave or partial return to work. • Strengthen the capacity of fit2work to support job retention and returns to work and strengthen its links with the health system, rehabilitation services and the PES.

OECD recommendations for Austrian policy on mental health and work *(cont.)*

Key policy challenges	Policy recommendations
4. High education spending should achieve better education and labour market outcomes for young people with common mental health problems	• Reorient education resources to increase qualified professional support for teachers and students, and ensure that teachers are literate in mental health and well supervised. • Expand the case-management approach of youth coaches and integrate available support effectively, which should include building closer links with the health system. • Secure sustainable transitions into the labour market for low-skilled, disadvantaged young people, who often suffer from mental illness, with a much-strengthened role for the PES.
5. The health system gives too little credence to the importance of good, workplace-oriented mental health care for people who suffer from common mental disorders	• Shift resources to improve mental health care, especially outpatient and primary care, child psychiatry, psychotherapy and the care provision in rural areas. • Give general practitioners a greater role and increase their competency in mental health care with a stronger focus on work. • Change the subsidised funding system for psychotherapy to increase ease-of-access for the mentally unwell, and match therapies more closely to needs to avoid driving costs up too much.

Chapter 1

Mental health and work challenges in Austria

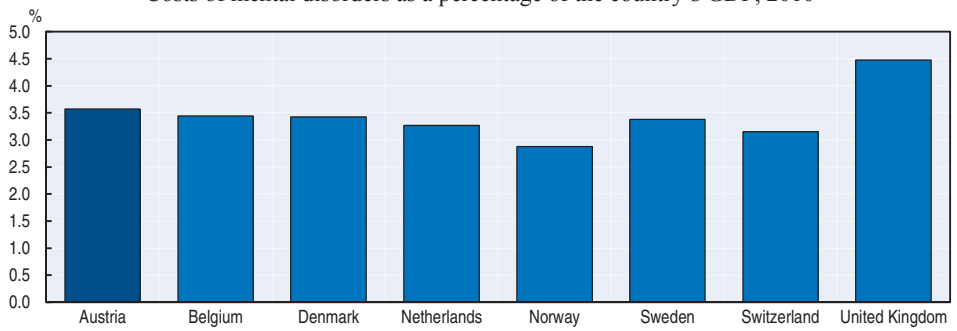
This chapter builds on the findings of the 2012 OECD report Sick on the Job? *to highlight the chief challenges Austria faces in the area of mental health and work. It offers an overview of the current labour market performance of people with mental health problems in Austria compared with other OECD countries, and looks at their economic well-being. The chapter also discusses some of the structural challenges Austria must rise to if it is to achieve comprehensive reform.*

The statistical data for Israel are supplied by and under the responsibility of the relevant Israeli authorities. The use of such data by the OECD is without prejudice to the status of the Golan Heights, East Jerusalem and Israeli settlements in the West Bank under the terms of international law.

Mental ill-health presents major challenges to the smooth functioning of labour markets and social policies in the OECD area. Yet countries have so far failed to address them adequately – a reflection of the widespread stigma and taboos that attach to mental health – even though society pays a high price. Direct and indirect costs stand at between 3% and 4.5% of GDP across a range of selected OECD countries. In Austria, mental disorders account for 3.6% of GDP (Figure 1.1).[1] Most of the cost does not come in the health sector. Indirect costs – social benefits, job losses, and under-performance and low productivity at work – are much higher than direct health care costs. According to Gustavsson et al. (2011), they account for 53% of the total cost to society of mental illness, while the figure for direct medical costs is 36%, and for direct non-medical costs 11%.[2]

Figure 1.1. **Mental disorders cost society dear**

Costs of mental disorders as a percentage of the country's GDP, 2010



Note: Cost estimates in this study were prepared on a disease-by-disease basis, covering all major mental and brain disorders. This chart includes mental disorders only.

Source: Gustavsson, A. et al. (2011), "Cost of Disorders of the Brain in Europe 2010", *European Neuropsychopharmacology*, Vol. 21, pp. 718-779 for cost estimates; Eurostat for GDP.

StatLink http://dx.doi.org/10.1787/888933239006

Definitions and objectives

According to the recent reports *Sick on the Job?* (OECD, 2012) and *Fit Mind, Fit Job* (OECD, 2015), policy needs to respond more effectively to the challenge of improving the labour market inclusion of people with mental illness. It must attend more closely to: mild-to-moderate mental disorders; problems that affect employed and unemployed people; and proactive measures to help people remain in work. The reports' conclusions draw on a number of findings, such as the sizeable employment rates of the mentally unwell coupled with low productivity at work and the high prevalence of poor mental health among people on unemployment, social assistance and disability benefits.

This report considers that a mental disorder is a condition that has crossed a clinical threshold and is diagnosed accordingly.[3] At any given time, some 20%-25% of the working-age population in the average OECD country therefore suffer from a mental disorder (see Box 1.1), with lifetime prevalence that can be as high as 40-50%.

Box 1.1. **Defining and measuring mental disorders**

A mental disorder is a condition which meets a set of clinical criteria that constitute a threshold. When it crosses that threshold it becomes a clinical disorder or illness that is diagnosed accordingly. Threshold criteria are drawn up by psychiatric classification systems like the Tenth Revision of the International Classification of Diseases (ICD-10), in use since the mid-1990s (ICD-11 is scheduled for release in 2017).

Administrative data on clinical conditions and disability benefit recipients generally include a classification code that denotes how a patient or benefit recipient has been diagnosed. Codes are based on ICD-10 and so attest that there is a mental disorder that can be identified. Such is the practice in Austria. However, administrative data do not include detailed information on an individual's social and economic status and cover only a fraction of all people with a mental disorder.

Survey data can, on the contrary, provide a wealth of information on socio-economic variables, while usually including only *subjective* assessments of the mental health status of the people surveyed. Nevertheless, surveys can measure the existence of a mental disorder through an instrument which consists of a set of questions on feelings and moods such as irritability, nervousness, sleeplessness, hopelessness, happiness, worthlessness. For the purposes of this work on *Mental Health and Work*, the OECD drew on consistent findings from epidemiological research across OECD countries to classify the 20% of the population with the highest values (measured by different mental health instruments in countries' survey) as having a mental disorder in a clinical sense, with the top 5% of values denoting "severe" disorders and the remaining 15% "mild-to-moderate" or "common" disorders.

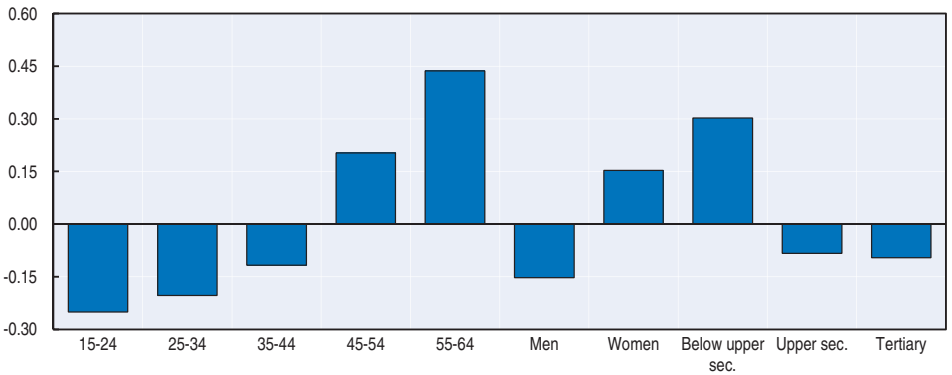
The methodology allows comparisons across the different mental health instruments used in different surveys and countries. OECD (2012) offers a more detailed description and explanation of the approach and its possible implications. Importantly, the aim in this report on Austria, however, is to measure the social and labour market outcomes of the mentally unwell, not the prevalence of mental disorders as such. To that end, the report takes data from a number of surveys:

- The Austrian Health Interview Survey 2006-07, which measures mental health status with the mental health and vitality items from the Short Form (36) Health Survey, known as SF-36 scale. (Newer data were collected between October 2013 and May 2015 but will be available only in late 2015.)
- Various international surveys – Eurobarometer 2005 and 2010; the European Working Conditions Surveys 2005 and 2010; and the Survey on Health, Ageing and Retirement (SHARE) 2010. OECD (2012) offers a summary of the mental health instruments used in these surveys.

In Austria, women, older adults (between 45 and 64) and people with low levels of educational attainment are more likely to report mental health problems than their peers (Figure 1.2). The age gradient is strong and deviates from those in most OECD countries where prevalence is higher in younger age groups (OECD, 2012).

Figure 1.2. **The prevalence of mental disorders in Austria varies with age, gender and level of education**

People with a mental disorder by age group, gender and educational attainment, relative to the overall prevalence in the Austrian working-age population, 2007



Note: "Below upper secondary" refers to Levels 0-2 in the International Standard Classification of Education (ISCED 0-2); "Upper secondary" to ISCED 3-4 and "Tertiary" to ISCED 5-6. More recent data from the Austrian Health Interview Survey 2014 will become available in late 2015 or early 2016.

Source: OECD calculations based on the Austrian Health Interview Survey, 2007.

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Understanding some key attributes of mental ill health is critical for devising good policies. They include: its onset at an early age; its varying degrees of severity; its persistent, chronic nature; high rates of recurrence; and frequent co-occurrence with physical or other mental illnesses. The more serious and enduring the illness, the greater the sufferer's degree of disability and the impact on their capacity to work. Although the exact diagnosis matters, mental illness of any type can be severe, persistent and co-morbid. Most mental conditions fall into the mild-to-moderate category, especially depression and anxiety disorders.

One important general challenge policy makers should address is the high rates of non-awareness, non-disclosure and non-identification of mental illness, all of which spring from the stigma that attaches to it. Indeed, it is not always clear whether more and earlier identification improves outcomes

or actually contributes to labelling and the risk of stigmatisation. The inference is that reaching out to the mentally unwell is what matters: policies that detect but do not openly identify mental illness will often work best.

The OECD report *Sick on the Job?* (2012) identified two main directions for reform.

1. Greater emphasis on preventing problems, identifying needs early and intervening promptly at key stages in life – during the transition from school to work, in the workplace, and when people are about to lose their job or to slide into the benefit system.
2. A coherent cross-government approach that integrates health and employment services and, where necessary, other services that support people who suffer from mental ill-health.

This report examines how policies and institutions in Austria are addressing the challenge of averting the labour market exclusion of the mentally unwell and ensuring that work contributes to better mental health. The structure of this report is as follows. The first chapter compares some key labour market outcomes among the mentally unwell in Austria with those in other countries, and then discusses some of the big underlying structural challenges in the system. The following chapters go on to look at how policy can rise to the challenge of supporting sufferers at critical junctures in their lives, such as when they are on brink of dropping out of the labour market and entering the benefit system or seeking to return to work. The chapters on policy challenges also consider life in the workplace and how employers intervene, followed by that crucial time just before a young person enters the job market. The last chapter examines the role of the health system and how it interfaces with employment services.

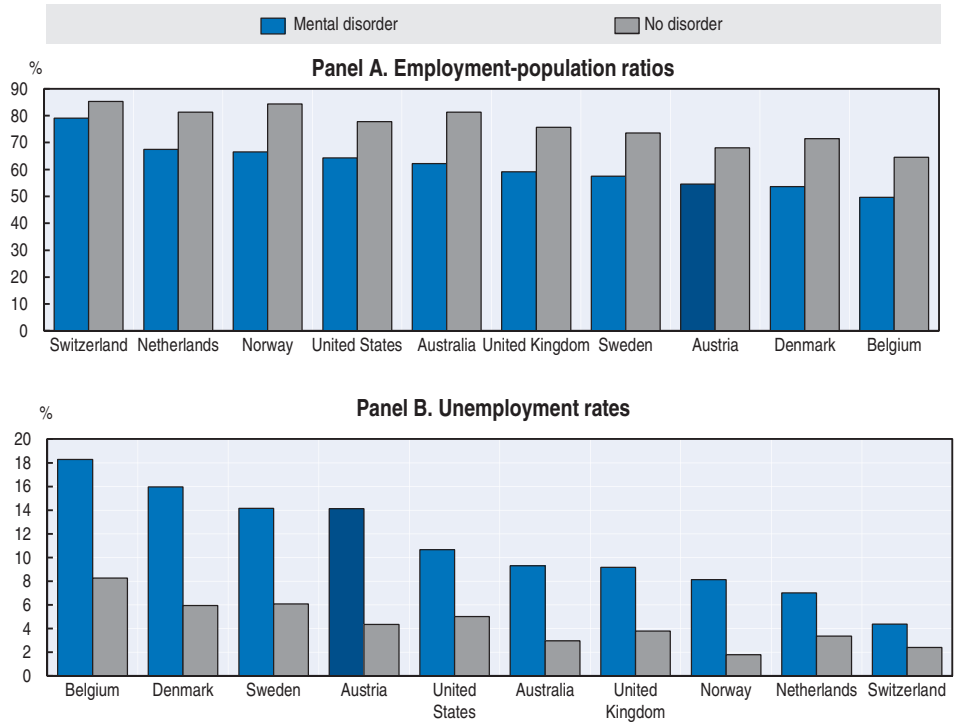
Trends and outcomes: Where Austria stands

At 55%, the employment rate among people with a mental disorder in Austria is significantly below the average in the ten OECD countries for which comparable data are available. (Most of the ten are top overall OECD performers in employment rates.) The mental health employment gap is comparable to the gap observed elsewhere, with the mentally unwell exhibiting a 20% lower employment rate than the mentally sound (Figure 1.3, Panel A). The most recent Austrian data pertaining to mental health status are for 2007, so there are none yet available for the years after the recent downturn. Overall, the impact of the economic crisis has initially been milder in Austria than in many other OECD countries. Yet the unemployment rate has risen steadily in the past few years, especially

among the low-skilled population (OECD, 2014), a group in which the mentally unwell people are highly overrepresented.

The unemployment rate of people with a mental disorder was very high in Austria even before the great recession. In 2007, it stood at 14% – thrice that of people without a mental disorder, a wider gap than in most other OECD countries (Figure 1.3, Panel B).

Figure 1.3. **Employment rates for people with mental disorders are mediocre in Austria and unemployment rates are high**



Note: More recent data from the Austrian Health Interview Survey 2014 will become available in late 2015 or early 2016.

Source: OECD calculations based on national health surveys. Australia: National Health Survey 2011-12; Austria: Health Interview Survey 2006-07; Belgium: Health Interview Survey 2008; Denmark: National Health Interview Survey 2010; Netherlands: POLS Health Survey 2007-09; Norway: Level of Living and Health Survey 2008; Sweden: Survey on Living Conditions 2009-10; Switzerland: Health Survey 2012; United Kingdom: Adult Psychiatric Morbidity Survey 2007; United States: National Health Interview Survey 2008.

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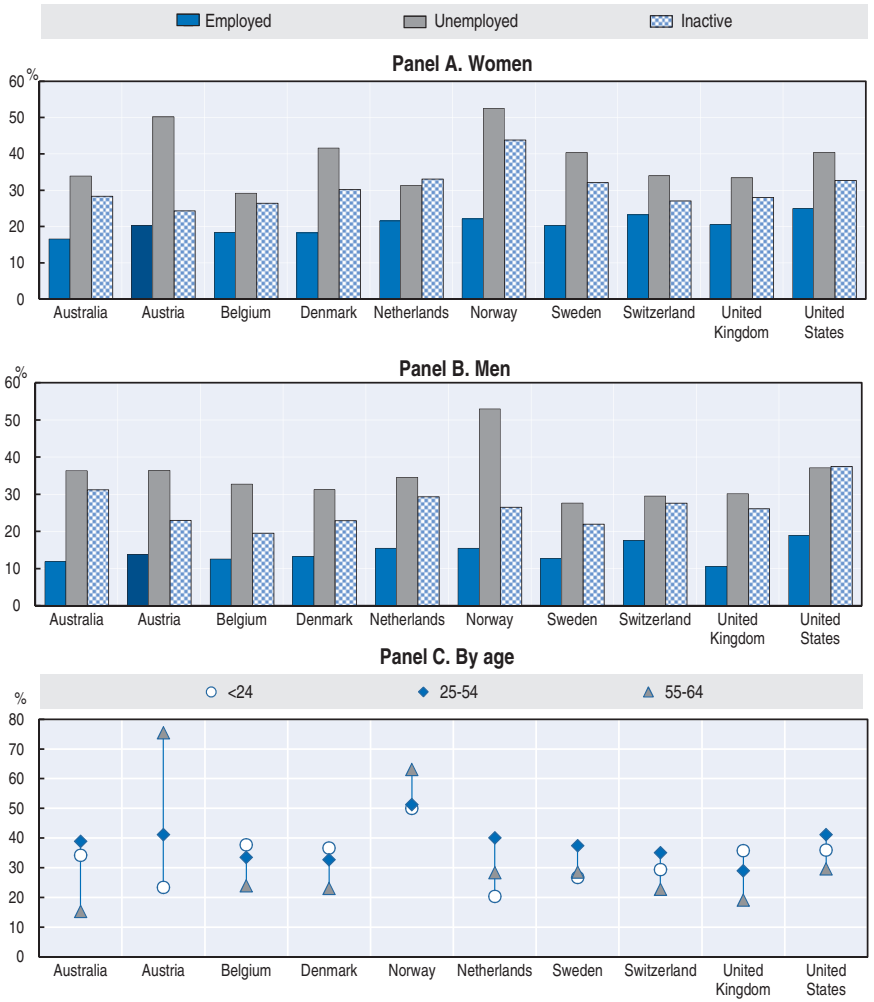
The joblessness among the mentally unwell in Austria is attributable to a link between unemployment and poor mental health that is more pronounced than in other countries (except Norway), especially among women. Every second unemployed woman in Austria reports having mental health problems, and over one in three men (Figure 1.4, Panels A and B). The correlation is even more marked when a third variable – age – enters the equation. Almost 80% of all Austrians aged between 55 and 64 years old who were unemployed at the time of the survey reported suffering from mental health problems. In other countries and among Austrians in the 25-54 age group, the figure is half that at around 40% (Figure 1.4, Panel C).

The strikingly high unemployment among older people is surprising at first glance. Yet it could well be related to a broader, albeit critical, issue: the low employment rate in Austria among 55-to-64 year-olds and the low average age at which people retire. The issue has been on the policy agenda for more than two decades to mixed effect. Employment rates in the 55-64 age group increased from about 28% in 2000 to 38% in 2007 and 45% in 2014. The average age of retirement, on the other hand, changed little, largely because workers are using disability benefit to take early retirement at a younger age (Chapter 2).

Figure 1.5 shows the strong link in Austria between age, poor mental health, and work: the employment rates among 55-to-64 year-olds are significantly lower when they suffer from severe or mild-to-moderate mental disorders. In Austria, age is viewed as an acceptable reason for leaving the labour market prematurely, particularly in conjunction with health issues. The employment gap between the mentally well and unwell in Austria is wider among older workers than in other countries, and unemployment acts as a bridge to premature labour market exit for those with mental disorders.

Figure 1.4. **The prevalence of mental disorders is high among unemployed people in Austria, especially among women**

Prevalence of mental disorder, by labour force status, gender and age, latest available year



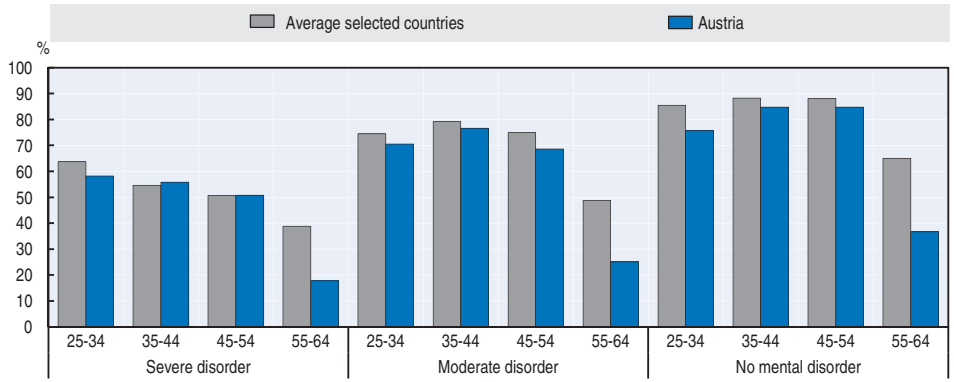
Note: More recent data from the Austrian Health Interview Survey 2014 will become available in late 2015 or early 2016.

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

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Figure 1.5. **Employment rates in Austria fall rapidly with age, particularly among people with mental disorders**

Employment rates by mental health status and age, latest available year



Note: The average is composed of Australia, Belgium, Denmark, the Netherlands, Norway, Sweden, Switzerland, the United Kingdom and the United States and is an unweighted average. More recent data from the Austrian Health Interview Survey 2014 will become available in late 2015 or early 2016.

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

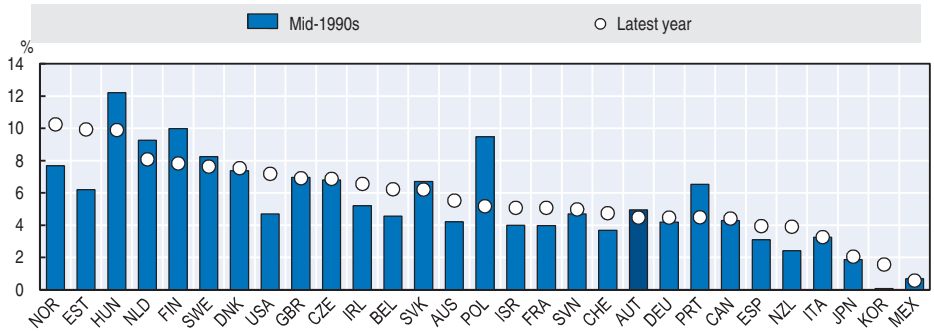
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Figure 1.6 further substantiates the critical age-related findings in Austria. The overall proportion of working-age people receiving a disability benefit is – at around 5% (not including civil servants) – lower than the OECD average (Panel A). The explanation is the significantly below-average recipiency rate among the under-45s. In the age group 55-64, the benefit caseload in Austria is higher than in Switzerland, for instance, where the recipiency rate of the under-45s is almost thrice that in Austria (Panel C). The rate among 55-to-64 year-old Austrians would probably be even higher, and similar to the level in Sweden, had early retirement on the grounds of a long insurance record been abolished already.

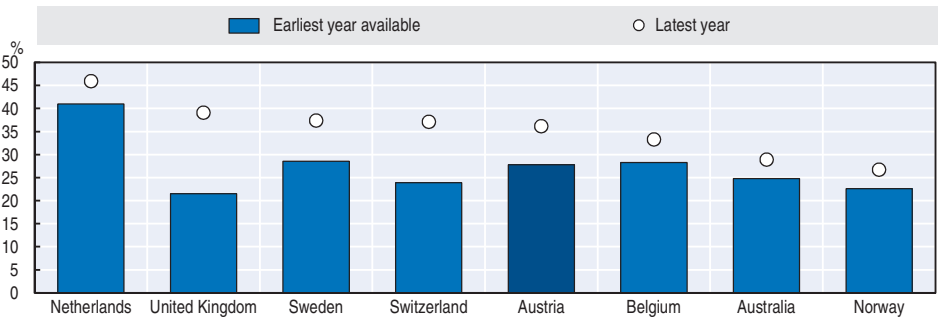
The share of mental disorders in the entire disability benefit caseload is as high in Austria as in most other OECD countries and has increased at a similarly rapid pace in the past decade (Panel B).

Figure 1.6. **There has been a rapid increase in the share of the mentally unwell claiming disability benefit**

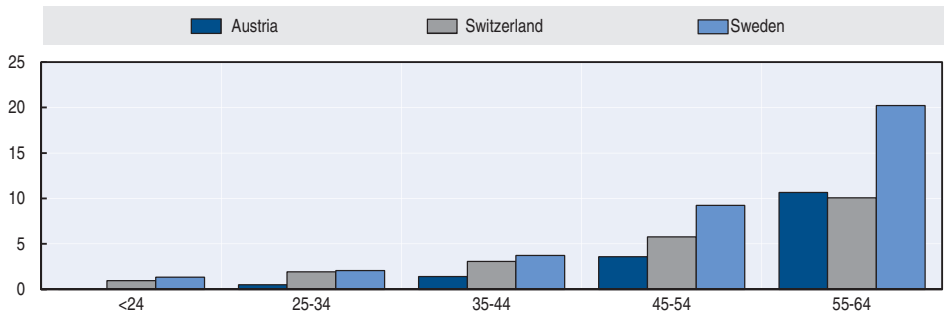
Panel A. Trends in total disability recipiency rates (in % of the population aged 20-64)[a]



Panel B. Share of beneficiaries with a mental disorder in the total disability caseload[a,b]



Panel C. Claim rates by age of disability beneficiary caseload, latest year available



a. Norway includes the temporary benefit in Panel A, but not in Panel B.

b. Data for Austria, Belgium, the Netherlands and Sweden include mental retardation, and organic and unspecified disorders.

Source: OECD calculations based on the OECD Disability questionnaire, the OECD Mental Health questionnaire and data from Austria's Federal Social Insurance Office for Austria.

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The Austrian context: Structural challenges for reform

Several of the challenges to the Austrian system are of a structural nature. Structural reform of the labour market and social policies is no easy task, however, because the federal government has often limited means and little power. It would take strong leadership to force through change unilaterally – e.g. by changing funding streams and structures – and any such attempts risk coming up against poor implementation. Successful reform requires convincing and including the actors responsible for implementing policy – the nine regions, social security, and the social partners. Without consensus, strong co-ordination, and collaboration across systems and institutions, reform will founder.

The power of the nine Austrian regions

Austria is a federal country whose nine regions, with populations ranging from 300 000 to 1.8 million, wield considerable power. Although taxes and social security contributions are almost exclusively collected at federal level, revenues are distributed to the regions through an agreed mechanism that is renewed by consensus every seven years or so.

Spending decisions are, to a considerable degree, in the hands of the regions. Education policy and much health policy are decided at regional and sometimes sub-regional level. And even federally designed policies in areas like social benefit and employment are predominantly executed by the regions. The PES's regional (and sub-regional) offices, for example, purchase specialised services for different risk groups from non-profit organisations, whose provisions and structures differ from region to region.

One consequence of Austria's federal governance structure is that different regions have significantly different policies and outcomes. Just how different policies and outcomes are, though, the federal government does not always know, because there is in several areas no national data collection system.

The powers of self-administered public entities

The challenge is not only to harmonise the interests and align the policies of the federal and nine regional governments. Another part of the equation, are Austria's highly independent self-administered quasi-public entities. Social security, for example, is self-governed. It encompasses health insurance, accident insurance and pension insurance (including the disability risk). What is more, there are 22 different insurance providers with considerable autonomy and sometimes responsible for different combinations of risks. There are nine regional providers, while others serve

occupations – public employees, farmers, and the railway and mining sectors, for instance, have their own insurance carriers.

Not only do all these bodies enjoy considerable decision latitude, their rules also often differ substantially. Indeed, the compartmentalisation of social security and its branches in Austria comes with considerable differences in systems and rules from one occupation to another. For instance, medical insurance, sickness, pension and disability benefit rules vary according to whether they cover employees, farmers, the self-employed or civil servants. Moreover, different rules apply within those insurance schemes – between blue- and white-collar workers, for example. Social security's deep-rooted structure would be difficult to change, however, even though it is outdated in today's mobile, flexible labour markets.

Added to all the above is the considerable influence of the social partners. The public employment service, for instance, is organised into one federal, nine regional and 99 sub-regional entities. The social partners are involved at every organisational level, in both the design of labour market policies and in supervising.

Data opportunities and limitations

Austria also has to contend with challenges pertaining to data and evidence. The country has a well-developed system of administrative data in various areas of social security and, through an individual identifier (the social insurance number) could in principle link different datasets relating to them. Even connecting administrative data with population survey data is possible, in theory. In practice, however, data protection and privacy laws prohibit such connections.

The current discussion over an electronic health record (ELGA) is a good example in that respect. There is agreement that doctors' visits, diagnoses and treatments should be stored on each person's individual record to improve information sharing among doctors and speed up treatment. But any information on diagnoses and treatment of psychological or psychiatric problems is to be deleted.

A further problem is the general lack of quantitative social and labour market policy evaluation in Austria. Where evaluations are carried out, they are generally qualitative for purposes such as measuring clients' and providers' satisfaction with a service. Rigorous evaluation of the actual impact of a reform or policy measure on employment outcomes, for instance, is rare.

Conclusion

The key facts that emerge from this round-up of Austrian policy on work and mental health and its challenges are:

- Mental illness exacts a high price from society – around 3.6% of GDP – as it does in the rest of OECD.
- The prevalence of mental ill-health increases with age and is highest among older workers. It is also greater among people with poor levels of educational attainment who also face the highest unemployment rates.
- Employment rates among the mentally unwell are lower than in comparable OECD countries. Much of the gap is attributable to the employment rate among 55-to-64 year-olds. It is low in all the population groups in that age range, but especially among the mentally unwell, whose labour market participation starts dropping after age 45.
- Austrian unemployment rates are generally low, but relatively high among people who suffer from mental ill-health – three times higher than among those who do not. The prevalence of mental ill-health is high among the unemployed, especially if they are in the 55-64 age group.
- The disability benefit caseload has been stable over time, close to the OECD average. However, in the past two decades mental illness has clearly emerged as the main factor in new benefit claims. Moreover, the longstanding problem of a system that encourages early retirement has yet to be turned round.

Notes

1. This report does not include in mental disorders such intellectual disabilities as mental retardation, specific conditions like learning disabilities and problems that develop later in life through brain injury or neurodegenerative diseases like dementia. Organic mental illnesses are also outside the scope.
2. Indirect costs in this study refer to productivity losses and the costs of benefits. Direct medical costs include goods and services related to the prevention, diagnosis and treatment of a disorder. Direct non-medical costs are all other goods and services pertaining to a disorder, e.g. social services.
3. The prime concern of the report is the mutual interplay between work and poor mental health. It uses a number of interchangeable terms that are general in scope to denote poor mental health – e.g. "mental ill-health", "mental disorder", "mental illness", "mental health problem" or "condition". It specifies, where necessary, whether a condition is serious or mild-to-moderate. Most sufferers grapple with the mild-to-moderate kinds of mental ill-health, which can be quite enough to affect their performance in the workplace, their employment prospects and, more widely, their place in the labour market.

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Chapter 2

Benefit reform in Austria to tackle widespread inactivity

This chapter looks at the role Austria's benefit system plays in providing people with mental ill-health with a secure income in periods of inactivity and helping them stay in, or return to, the labour market. The chapter focuses particularly on the 2013 disability benefit reform. To tap into its considerable potential, Austria must rise to the challenge of implementing rigorously the new roles of various institutions. Issues are discussed against the backdrop of the frequent mental health problems among people who receive working-age benefits and the fast increase, over the past twenty years, in the number of disability benefit claims for reasons of poor mental health.

The Austrian benefit system is well developed, yet fragmented. The four main working-age benefits – unemployment, sickness, disability and social assistance – come fully or partly under the jurisdiction of different authorities. They also have different payment structures, durations, eligibility criteria and – most important – different activation requirements. Such a complex setup is not conducive to preventing mentally unwell workers from exiting the labour market or helping them to return swiftly to work.

The recent disability benefit reform in 2013 is the Austrian government's first attempt to address the fragmentation of its benefit system and foster a job-oriented approach where the labour market authorities are responsible for mentally unwell workers as long as they have some capacity to work. The reform particularly affects the way the Pension Insurance Authority (PIA) interacts with the public employment service (PES) and health insurance providers. It seeks to respond effectively to the fast increase over the past two decades in disability benefit claims related to mental health.

The authorities will face considerable challenges in the coming years in implementing the disability benefit reform in such way that it yields the expected results. Even if the reform is successful, however, the authorities that pay out unemployment and social assistance payments will have to deal more effectively with the large number of clients affected by mental health problems. In that regard, it is important that they also rigorously implement a recent social assistance reform, in place since 2011, which is more firmly geared to PES clients finding or resuming work.

The rising mental health challenge to the benefit system

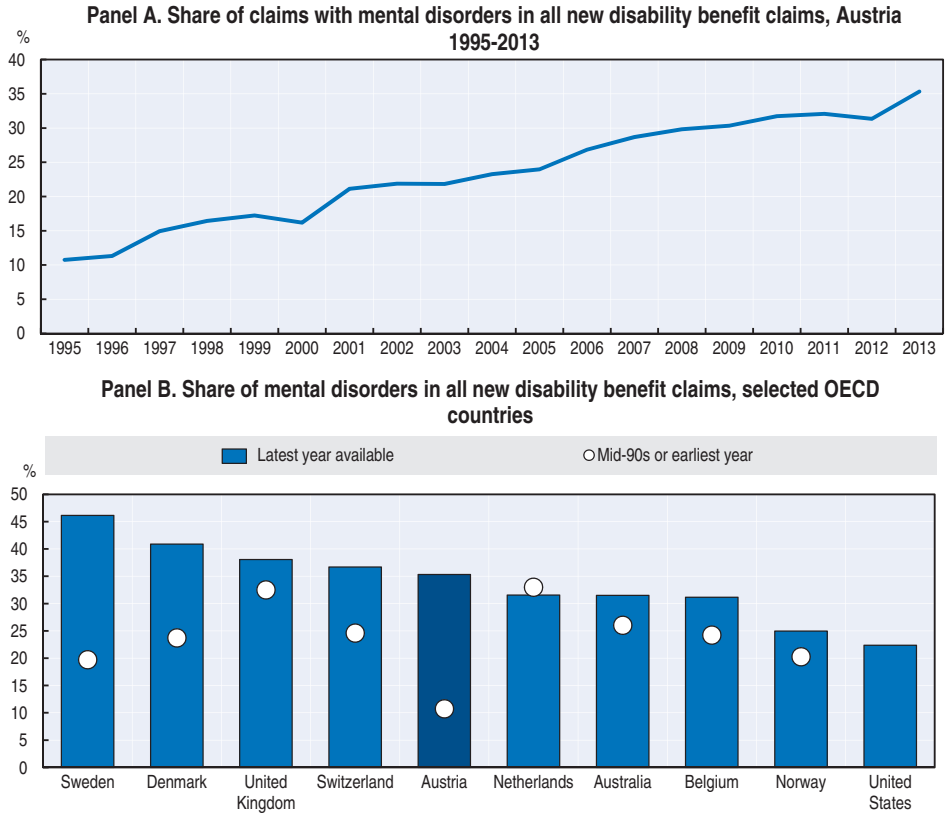
The changing structure of disability benefit claims

Since the mid-1990s, Austria has seen a remarkable increase in the share of disability benefit claims caused by mental illness – from some 10% of all claims in 1995 to roughly 20% ten years ago and 35% more recently (Figure 2.1, Panel A). Such claims rose at a much faster rate in Austria than in other OECD countries, largely because there were initially fewer. Although the figure is now in line with that in comparable OECD countries, it is still lower than in a few others – prompting fears that it may well increase further (Figure 2.1, Panel B).

What explains the increase in mental health claims? In a comparison of trends in health conditions in a number of countries, the OECD (2012a) attributed it – in part, at least – to a shift in the way that

the causes of disability and work incapacity were *assessed*, not to changes in *actual* causes. Put more bluntly, while only physical illness used to be taken into consideration, the high occurrence of co-morbidity in and greater awareness of mental illness, together with the lower stigma attaching to it, have seen it gain greater recognition.

Figure 2.1. **Disability benefit claims are increasingly caused by mental disorders**



Note: Data for Austria, Belgium, the Netherlands and Sweden include mental retardation, organic and unspecified mental disorders (data do not allow to separate out these causes). The comparable figures for these countries would be around one-sixth lower.

Source: Panel A: Ministry of Labour, Social Affairs and Consumer Protection and Panel B: OECD calculations based on the OECD questionnaire on mental health.

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However, physical causes are still more widespread among blue-collar workers, while poor mental health accounts for most disability and incapacity claims in the service sector, especially in health, the social services, commerce and tourism. So, while it is plausible that stigma has persisted in unskilled jobs, the shift towards more skilled jobs and a service economy seems to play a role in the increase in mental health-related disability benefit claims.

There are also wide differences across Austria's regions in claims stemming from mental disorders, with disparity ratios sometimes reaching 1/3 or even 1/4. Claim rates are highest in the agricultural and industrial region of Styria and in Tyrol, which relies on farming and tourism. Differences of such magnitude are not explicable by differences in assessment methods as they are largely centralised (see below). Regional authorities do seem to have some say, though, because there are considerable disparities (in the order of 1/2) in both benefit claim and award rates. More research is needed to better understand and adequately respond to such large regional discrepancies.

Claimants with mental disorders are quite distinct from other claimants in various ways (see below). According to data from 2013, they are, for example, generally younger – the average age at which they are granted their first disability benefit being about 48 years old, compared to 56 among other groups of claimants. They also receive disability benefit payments for longer. The increase in the share of mental disorder claims would thus appear to be a factor in the lower average age of claimants, longer payment durations and, therefore, in greater public spending on disability benefits.[1]

Disability benefit claims for reasons of poor mental health are also much more frequent in Austria among women than men. The trend is related, on one hand, to the higher prevalence of mental illness in women of all ages and, on the other, to the economic structure, with fewer women working in traditional blue-collar jobs.

High prevalence of mental ill-health in benefits other than disability

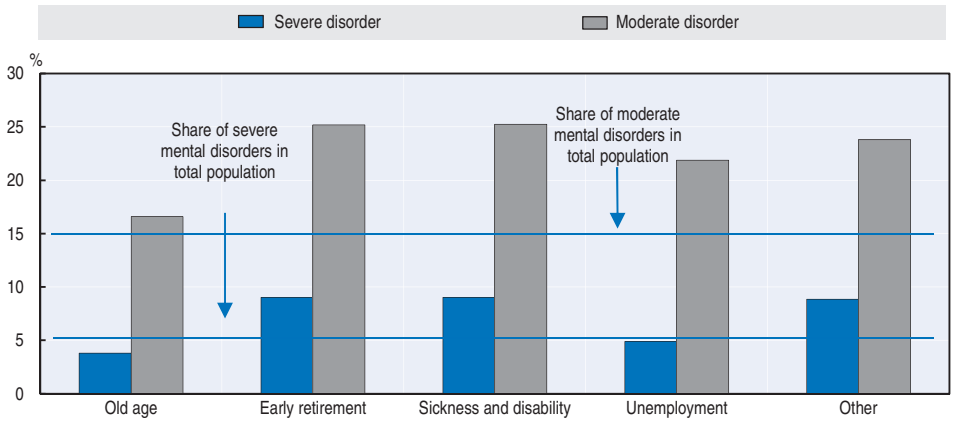
The recent rise in disability benefit claims on the grounds of mental ill-health is important and calls for policy change. However, the benefit system faces a much bigger challenge: the high share of mentally unwell people among other working-age benefit claimants, such as sickness, unemployment and social assistance. That challenge still goes largely unheeded, though, because the group of claimants it concerns receives scant attention.

There is a serious dearth of data on the prevalence of mental ill-health among benefit claimants in Austria. Administrative data do not generally include their health status, while survey data linking health and benefit status are virtually non-existent, too. The International Survey of Health, Ageing and Retirement (SHARE) is the only source that can be used, and even it is limited insofar as it covers only the population aged 50 and over. Given the low employment and high disability benefit rates among older workers in Austria, however, SHARE's data for 50-64 year-olds are relevant.

Around one-third of all benefit recipients among 50-64 year-olds suffer from mental illness, with only slight differences from one working-age benefit scheme to another (Figure 2.2). Only among people who receive a normal old-age pension, do the mentally ill account for a share, 20%, similar to the share in the total population. (People with severe mental illness are actually under-represented among old-age pensioners.) The distribution of mental disorders among people on early retirement benefit or social assistance (included in the group "Other" in Figure 2.2) seems, in particular, to be much the same as among those claiming sickness and disability benefit. The share of mentally unwell unemployment benefit recipients is slightly lower – just under 30% – largely because there are fewer people with severe mental disorders who claim such benefit.

Figure 2.2. **Mental health problems are frequent among benefit recipients**

Distribution of mental disorders among recipients of different benefits aged 50-64, 2010



Source: OECD compilation based on the Survey of Health, Ageing and Retirement (SHARE).

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The above findings are confirmed by estimates of mental health prevalence according to labour force status for the entire working-age population (see Figure 1.5 in Chapter 1). They show that over 40% of the jobless in Austria (including those who do and do not receive unemployment benefit) suffer from a mental illness.

That critical finding is not sufficiently reflected in benefit policy or procedures which – aside from sickness and disability benefits – are little concerned with a claimant's state of health. More research is needed on the type and nature of benefit recipients' mental and physical health problems and the degree to which they hinder successful returns to work. Recent research has documented the high incidence of health problems among social assistance clients. They show a considerable disconnect from the labour market, with every second client reporting health problems, and even higher shares among older adults (Riesenfelder et al., 2011).

Disability claimants are a vulnerable group of workers

Longer-term developments in disability benefit recipiency

In many OECD countries, disability benefit rolls have steadily increased in the past 20-25 years, as deindustrialisation has brought structural change that has driven significant numbers of the long-term unemployed to switch to disability benefit (OECD, 2010). Other countries with more stringent disability benefit schemes, by contrast, boast stable recipiency rates (i.e. beneficiaries as a share of the total population). The latter pattern is true of Austria, where recipiency stands at between 5.5% and 6% (including civil servants) and is close to the OECD average.

Overall benefit dependency in Austria's working-age population has also been steady for the past few decades, albeit at a high level, with close to 20% receiving a payment (Loos et al., 2009); this may be broken down as follows:

- 6% on disability benefit
- 2% on sickness benefit
- 4% on unemployment benefit (though recently more)
- 3% on early retirement
- 3% on social assistance
- 1.5% on a work injury payment.

Most of these percentages have remained stable over time – only the social assistance rate has increased steadily since the mid-1990s. The stability is related to a welfare system that has seen little change for a long time. Recent benefit reforms discussed in detail later in this chapter have the potential to bring change.

The major challenges to the disability benefit system in Austria are twofold:

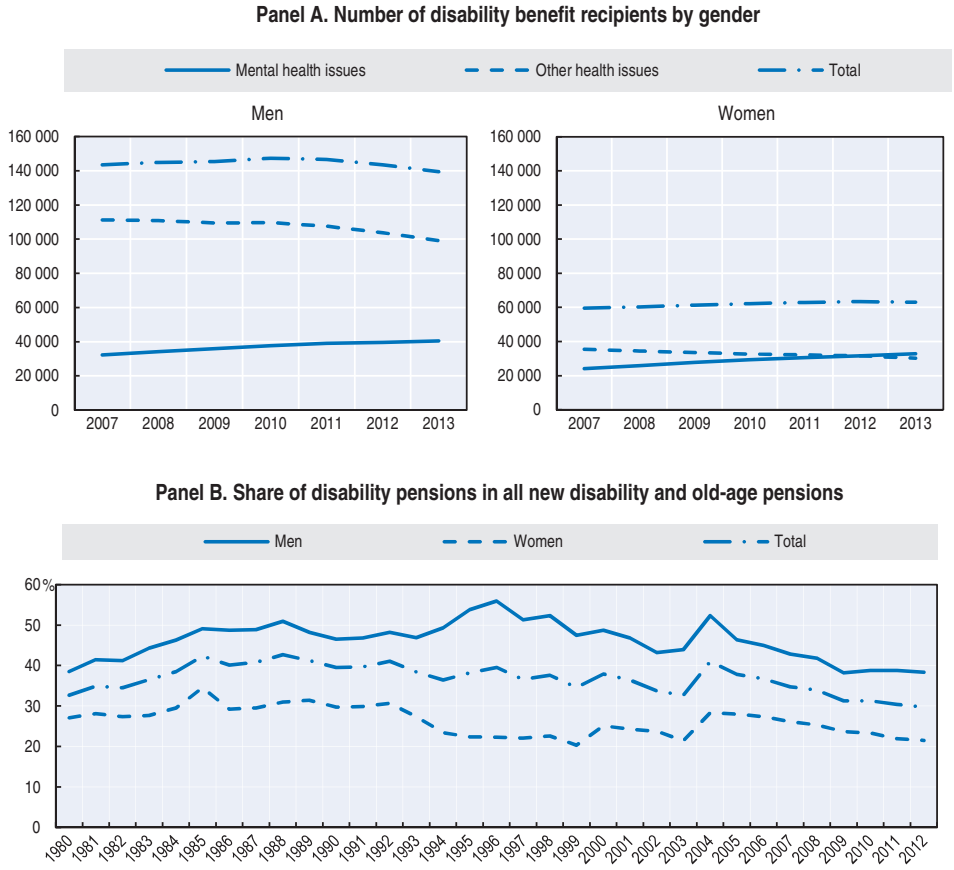
1. The continuous increase over the past 20 years in the number of claimants with mental disorders (Figure 2.3, Panel A) who are further removed from the labour market than the average claimant.
2. The frequent use of disability benefit as an early retirement pathway. Since 1980, between 30% and 40% of the Austrian workforce have retired on the grounds of disability, with the share among men being even higher (Figure 2.3, Panel B).

Austria thus has to address a new problem and a longstanding one.

Austria's situation is characterised by the sharp contrast between how hard it is for young people to claim disability benefit and how much easier it is for older workers. The disparity is thrown into relief by comparison with new claim rates in other OECD countries. Among young Austrians they are far lower, while those of older adults are among the highest in the OECD. They are, for example, much higher than in two other small European countries with similar overall disability benefit recipiency rates, Denmark and Switzerland (Figure 2.4).

In Austria, consequently, the claim rate among 55-64 year-olds is 11 times higher than in the 25-34 age group. Typically the ratio is closer to 3/1 in other countries (see also OECD, 2005).

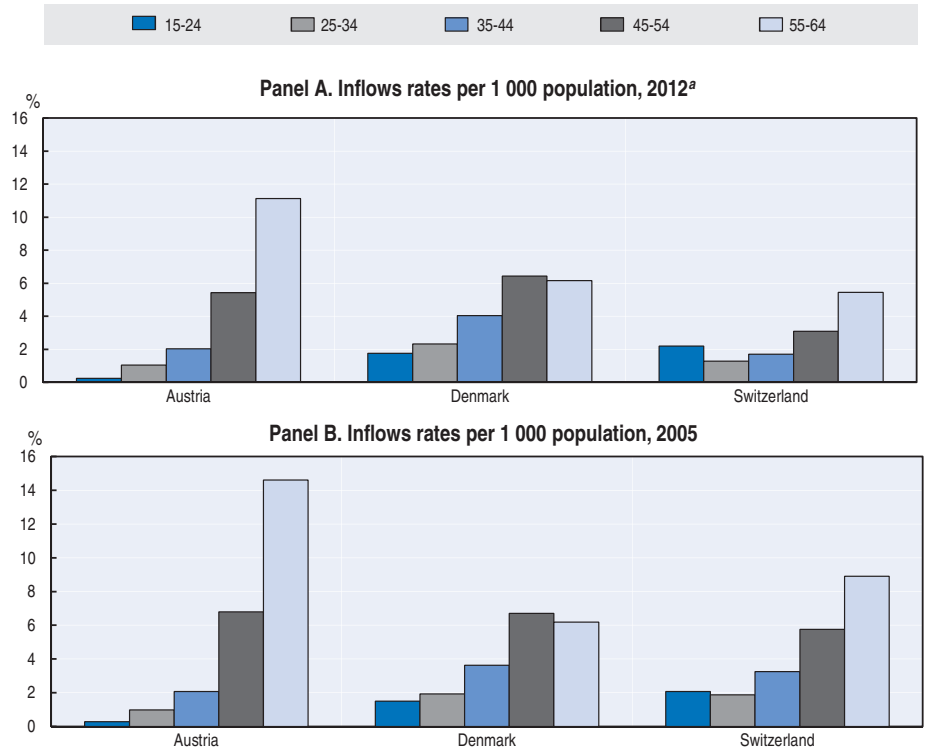
Figure 2.3. **Disability benefits often act as a pathway to retirement**



Source: Panel A: Ministry of Labour, Social Affairs and Consumer Protection. Panel B: Fakten und Trends bei den Invaliditätspensionen, BMSK, II/6.

StatLink http://dx.doi.org/10.1787/888933239082

Figure 2.4. **In Austria, people aged 55-64 are several times more likely to claim a disability benefit than those in the 25-34 age group**



a. Data refer to 2011 for Denmark.

Source: OECD calculations based on data from the OECD Mental Health questionnaire and the Ministry of Labour, Social Affairs and Consumer Protection for Austria.

StatLink http://dx.doi.org/10.1787/888933239099

The disparity between young and older claimants in Austria may be explained largely by eligibility criteria:

- Five years of social security contributions, which excludes younger people who have little or no work record from claiming benefit.
- Own-occupation assessment, which makes it easier for people who have training or longstanding experience in a particular profession to access benefit.
- Criteria are looser for the over-57s (previously the over-55s and in the future the over-60s) whose capacity to work is assessed only against their most recent main job in the workplace.

Employment histories are patchy among the mentally ill

Many people applying for disability benefit have been through periods of patchy employment which can often last a number of years. Around three in ten new disability benefit claims originate in unemployment, usually long-term (Table 2.1, Panel A). Mentally unwell claimants are frequently even further removed from the labour market, with as many as 40% of them unemployed at the time of their claim (Table 2.1, Panel B). Another one-third is on sick pay.

Table 2.1. **Disability benefit claims are often preceded by unemployment, especially claims for mental illness**

Panel A. Distribution of new disability benefit claims by status before the benefit claim, men versus women, 2006-2012

	Men			Women		
Status before benefit claim	2006	2009	2012	2006	2009	2012
Employed	27.3	28.0	29.3	24.1	20.4	19.5
On sick pay	27.1	27.2	29.0	31.5	34.6	36.8
Short-term unemployed	12.3	14.2	12.4	10.4	12.5	11.6
Long-term unemployed	24.4	21.0	22.5	19.8	17.1	20.0
Unemployed with pension pre-payment	4.9	4.4	2.3	4.0	3.9	2.6
Other	4.0	5.2	4.5	10.2	11.5	9.5

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

	Mental	Musculoskeletal	Other	Total
Employed	19.2	53.4	35.3	36.0
Self-employed	1.3	0.7	0.9	1.0
On sick pay	31.8	14.1	32.7	26.4
Unemployed	40.7	26.0	24.4	30.2
Other	7.1	5.8	6.6	6.5

Note: Data on the employment status by health condition prior to claims are estimated in a slightly different way; hence, the difference between figures in Panel A and Panel B.

Source: Ministry of Labour, Social Affairs and Consumer Protection, www.sozialministerium.at (BMSK report Table 2.3.1 for 2006) accessed 1 June 2015.

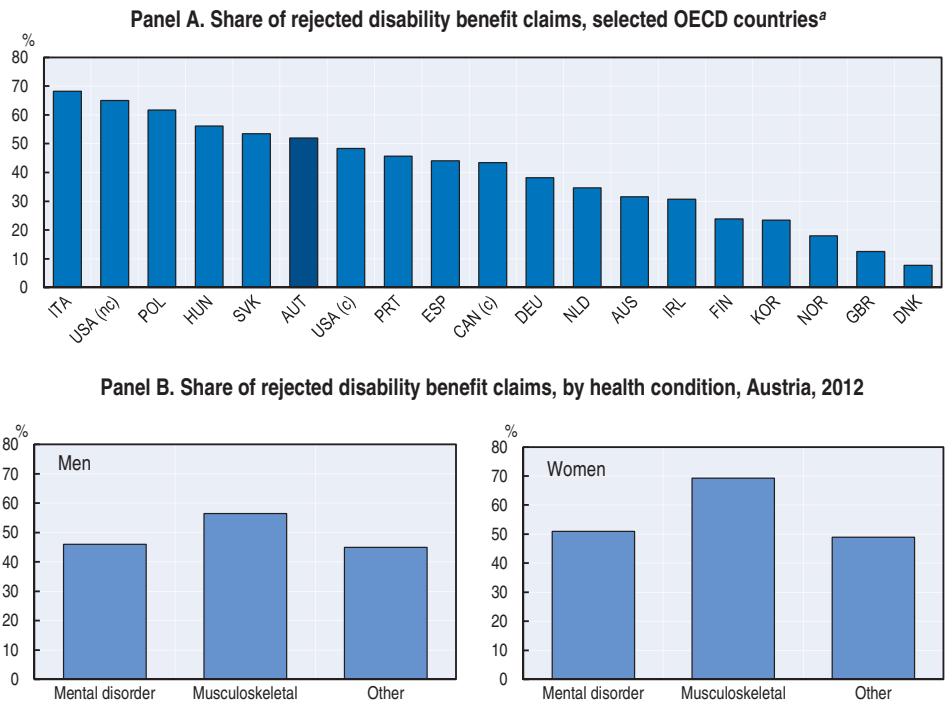
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Clearly, unemployment and sickness benefit schemes have a key role to play – particularly among the rising number of mentally unwell claimants – in preventing long-term labour market exit. Indeed, the roles of these systems are likely to assume even more importance when the latest disability benefit reform kicks in (see below).

Benefit rejections and repeat applications are common

A prominent issue in Austria, as in many other OECD countries, is the very high benefit rejection rates. More than one in two disability benefit claims are denied, one of the highest shares in the OECD area (Figure 2.5, Panel A).

Figure 2.5. **In Austria half of all new disability benefit claims are rejected**



Note: "c" denotes contributory benefits only; "nc" denotes non-contributory benefits only.

a. Data refer to 1999 for Germany, Italy, Korea, Portugal, Spain and the United States ©; 2004 for Poland, 2007 for Canada, Ireland, the Slovak Republic and the United States (nc); 2008 for Austria, Finland, Hungary, the Netherlands and Norway; 2009 for Australia, Denmark and the United Kingdom. Data for Ireland refer to people applying for sickness benefit after two years, for the United Kingdom to the long-term incapacity benefit, and for Poland to the KRUS scheme only.

Source: Panel A: Figure 3.3. OECD (2012), *Mental Health and Work: Norway*; Panel B: Stefanits, H. et al., (2009), "Invaliditätspensionen – Anträge, Ablehnungen, Zuerkennungen", *Soziale Sicherheit*, Vol. 9/2009, pp. 422-435.

StatLink http://dx.doi.org/10.1787/888933239104

Austria's claim refusal rate has been stable over time, and always higher among women than men and among blue-collar workers than any others. Although differences by type of health condition are slight,

claims on the grounds of mental disorder are denied less often than for physical complaints (Figure 2.5, Panel B). One reason is the higher likelihood of the mentally unwell being deemed unfit to work. Another could be the inability of the available tools to measure the capacity to work, which is – in turn – related to the general stigma that attaches to mental illness.

Many of those whose claims are turned down do not return to the labour market. Instead, they are likely to navigate within the benefit system or move in and out of short-term, insecure employment, only to reapply for disability benefit again at a later stage. Evidence is limited, however, and nothing is known about the extent to which mentally ill claimants who have been rejected behave differently from other claimants. Of all those who were granted a disability benefit in 2008, almost four out of ten had had at least one claim denied in the previous five years (Table 2.2, Panel A). And of those claimants who were rejected in 2008, it was the second time for 23% of them, the third time for 11%, and the fourth or fifth time for 5% (Table 2.2, Panel B). Blue-collar workers see their benefit claims turned down more frequently than white-collar workers.

Table 2.2. **Repeat applications and repeat rejections are frequent in Austria**

Distribution of benefits granted and denied in 2008 among blue- and white-collar workers according to the number of previous refusals in the period 2004-08

Panel A. Granted applications

	Number of times claim was rejected					
	0x	1x	2x	3x	4x	5x
White-collar workers	71%	22%	5%	1%	0%	0%
Blue-collar workers	60%	27%	10%	3%	0%	0%
Total	63%	25%	9%	2%	0%	0%

Panel B. Rejected claims

	Number of times claim was rejected					
	0x	1x	2x	3x	4x	5x
White-collar workers		70%	21%	8%	3%	0%
Blue-collar workers		57%	24%	12%	5%	1%
Total		60%	23%	11%	4%	1%

Source: Stefanits, H. et al., (2009), "Invaliditätspensionen – Anträge, Ablehnungen, Zuerkennungen", *Soziale Sicherheit*, Vol. 9/2009, pp. 422-435.

StatLink http://dx.doi.org/10.1787/888933239438

When someone has their disability benefit claim refused, they often just slip back into their previous situation (mostly unemployment), with no special support kicking in either from the PIA (which treats all new claims equally) or the PES (which keeps no record of a jobseeker's disability benefit rejections). Such failure to provide support is a missed opportunity because rejected disability claimants are a highly vulnerable group unlikely to find stable employment and likely to need multidisciplinary help. And many of them suffer from mental illness.

A recent study by Fuchs (2013) was the first to look into the further employment careers of people whose disability benefit had been rejected. It considered benefit rejections in 2004 and people's social security record between 2005 and 2009. Fuchs' findings were striking.

On average, people were employed for no more than half a year in the subsequent 5-year period, while 2.5 years were spent unemployed and 2 years were spent living on an allowance – usually from disability benefit because almost half of those rejected eventually succeeded in getting their claims accepted (Table 2.3). Over 60% of rejected claimants never worked again – not even a single day – and only 2% worked for the entire five-year period. Rejected white-collar workers did slightly better than their blue-collar peers, but even among them going back to work was an exception.

Table 2.3. **Employment trajectories are very piecemeal after a benefit rejection**

Main labour force status during 2005-09 of blue- and white-collar workers with rejected disability benefit claims in 2004, by gender

	Time spent in different activities in 2005-09 (in years)				
	Employment	Unemployment	Sick pay	Benefit receipt	Total
Male blue-collar workers	0.39	2.61	0.01	1.99	5.00
Female blue-collar workers	0.55	2.49	0.02	1.95	5.00
Male white-collar workers	0.73	1.97	0.01	2.29	5.00
Female white-collar workers	0.69	2.08	0.02	2.22	5.00
All groups together	0.51	2.43	0.02	2.04	5.00

Source: Fuchs, M. (2013), "Die weitere Erwerbsbiographie von Arbeitern und Angestellten, deren Antrag auf Invaliditätspension abgelehnt wurde", *Soziale Sicherheit*, Vol. 5/2013, pp. 256-265.

StatLink http://dx.doi.org/10.1787/888933239440

These findings have not found their way into policy. Indeed, once people apply for disability benefit, they are largely lost to the labour market – possibly because they feel that their working life has come to an end. The only way that Austria can tackle labour market drop-out is by preventing and discouraging disability benefit applications through faster, stronger activation and intervention among the (long-term) sick and unemployed who are at risk. Austria must also strengthen medical and vocational rehabilitation. The latest disability benefit reform, which seeks to restrict eligibility to disability benefit, could be part and parcel of such an improved approach.

Rigorous implementation of the 2013 disability reform is critical

Disability benefit reform to reduce the number of claims

The Austrian disability benefit scheme has seen little structural change in the past few decades. Only the introduction of a special early retirement scheme with reduced work capacity in the mid-1990s, and the subsequent abolition of the scheme in 2004, has had any significant impact on claimant numbers. In late 2012, however, the government agreed on a comprehensive reform with considerable potential for curbing disability benefit claims. Its objective is to bring into or back to the labour market people affected by chronic health problems or disability who have some capacity to work (see Box 2.1).

In short, except for people permanently and totally unable to work ("totally" meaning unable to perform any job in the Austrian economy), it will no longer be possible to access disability benefit. Instead, there are two alternatives:

- Those who are temporarily too sick to work and in need of treatment will be entitled to *rehabilitation* benefit (essentially an extended sickness benefit). Hitherto, such people have had to apply for a temporary disability benefit – a *de facto* dead end which is now to be abolished.
- Those who are fit enough to work but unable to return to their own occupation will be entitled to a *retraining* benefit (a special unemployment benefit with a 22% top-up). They will also receive retraining in a "comparable" occupation.[2]

The new rules, applicable since January 2014, are being phased in gradually and apply to everyone who was under 50 when the reform was introduced – i.e. 1964 birth cohorts and younger. Over the coming 15 years the changes will gradually extend to the entire working-age

population – contrary to the initial plan to reform the system only for claimants under 50, which would have wrought very little change in a country where older workers account for the bulk of new claims.

A major drawback, however, is that the reform will affect only blue and white-collar workers. It will not apply to civil servants, farmers or the self-employed (all of whom have their own insurance and protection schemes). The restricted scope is highly problematic because farmers and civil servants enjoy easier access to disability benefits. The contention that farmers could not be retrained for any other profession does not bear scrutiny when it comes to civil servants.

Box 2.1. **Main features of the 2013 disability benefit reform in Austria**

The 2013 disability benefit reform comprises the following main changes:

- Abolition of temporary disability benefit.
- Abolition of the advance pension (which rules out PES interventions because people will no longer have to be available to work).
- Restriction of disability benefit to people permanently unable to do any work.
- Introduction of a rehabilitation benefit paid by health insurance to those temporarily unable to work. Rehabilitation benefit is not a temporary payment, although recipients' health will be reassessed regularly (at least once a year). Payment is identical to sickness benefit, which is normally 60% of the last wage.
- Introduction of a retraining benefit paid by the PES to people unable to work in their own profession but otherwise able to work. Payment is equal to unemployment benefit, but with a 22% top-up (in order to raise the average payment level to the level of an average disability benefit).
- People on either rehabilitation or retraining benefit are legally entitled to medical (physical or psychiatric) and vocational rehabilitation if it is necessary for rebuilding the capacity to work.
- People on retraining benefit will receive high-quality retraining for another job provided by the PES. (The PIA covers the costs of such retraining.)

The reform is applicable to everyone under 50 at the time of the reform. The expectation is that between 2014 and 2018 around 15 000 people will receive retraining benefit and around 23 000 rehabilitation benefit. The lower disability benefit spending is estimated to lead to public savings of around EUR 700 million between now and 2018.

The government is optimistic about reaping substantial gains from the reform. Initial data for 2014 suggest that the number of new disability benefit grants has fallen by 16% overall and even by as much as 22% when blue and white-collar workers only are considered. One result has been a rise in the age at which people access disability benefit, especially among those with a mental disorder (up by 3.5 years). Most of those people are now on rehabilitation, not on retraining, benefit. Of those who received rehabilitation benefit in 2014, almost 60% did so for a mental disorder.

Those numbers are promising but the long-term success of the reform will hinge entirely on its implementation. Several stakeholders who are to play a critical part in rigorously enforcing the reform are sceptical that it will change much in reality. There is a great risk that the reform could eventually founder if it fails to address other structural problems in the system. Rehabilitation benefit could – like temporary disability benefit in the past – turn into a stepping stone on the way to permanent disability. And the retraining scheme could end up as just a higher benefit for the long-term unemployed.

The authorities concerned must introduce mechanisms that ensure reform is enforced rigorously and effectively. Those authorities are the PIA, the health insurance providers who manage rehabilitation benefit and follow-up, and the PES, whose remit includes retraining action and benefit payment. All will have to deliver.

Lessons from the past and other countries

Will there be more successful medical rehabilitation?

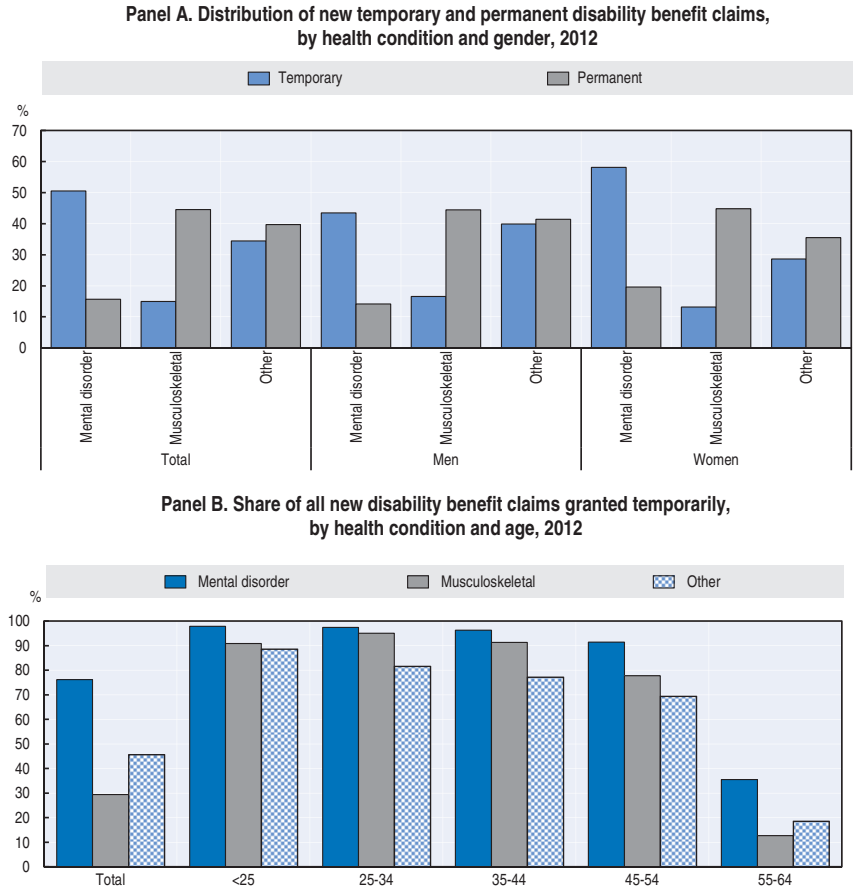
More than a decade ago, Austria significantly changed the way in which it awarded disability benefit and an increasing share of new benefits were granted temporarily. That rise was partly related to the upward trend in new claims for reasons of mental illness which accounted for around 50% of all new temporary benefit grants, but only a small share of new permanent benefit awards (Figure 2.6, Panel A).

In 2012, three in four new claims on the grounds of mental disorder were granted temporarily, compared to only 30-45% for other health conditions (Figure 2.6, Panel B). The disparity may, to a significant degree, be ascribed to the close correlation between health and age: the older the claimant, the narrower the difference. Irrespective of the nature of their condition, the under-55s are generally granted benefit temporarily and the over-55s permanently. One-third of the latter who were on permanent benefit for reasons of poor mental health were

initially on temporary benefit. For other health conditions, the proportion was one-sixth. Of the mentally unwell under-55s, more than 90% receive their benefit only temporarily to begin with.

Austria's focus on age-related eligibility criteria is problematic. Age is neither a good proxy for current work capacity nor a good predictor of future capacity. Focusing on it reinforces the acceptance in Austria of disability benefit as an early retirement pathway and hinders the optimum use of a person's remaining capacity to work.

Figure 2.6. **Disability benefit for mental disorders is typically granted temporarily**



Source: OECD calculations based on data provided by the Ministry of Labour, Social Affairs and Consumer Protection, www.sozialministerium.at (accessed 1 June 2015).

StatLink http://dx.doi.org/10.1787/888933239110

In reality, the shift in Austria towards granting disability benefit only temporarily was ineffectual. No intervention or activation was offered during periods of benefit receipt. The sole policy was just to wait for the health condition to improve. Temporary payments merely postponed permanent benefit, and most did eventually turn permanent.

The explanation for this is closely linked to the experience of people whose benefit claim is rejected. The authorities intervene too late – when people are already too far down the road to retirement for rehabilitation or retraining to be effective, which is probably why intervention is in fact not even offered.

Lessons from other countries are similar. Rarely do temporary disability benefits lead to anything other than a permanent claim at a later stage. In Norway, the situation even worsened when a temporary disability benefit was introduced: authorities became more lenient in granting payment, especially to younger claimants, thinking it was only temporary. But very few claimants have subsequently moved off benefit. Indeed, the overall rate of new benefit awards – and, in turn, the benefit caseload – increased (OECD, 2006). Accordingly, Norway abolished temporary benefit again only a few years later, combining it with rehabilitation benefit into a new Work Assessment Allowance with a stronger focus on work (OECD, 2013a).

The new rehabilitation benefit in the Austrian system is an extended sickness benefit which replaces temporary disability benefit. That change alone will not have any positive impact unless it gives rise to new ways of apprehending disability benefit claimants with new forms of monitoring, activation and intervention. The effect of the reform will now be that health insurance takes over from the PIA. Health insurance has hitherto played no role in managing sickness other than through eligibility controls to prevent misuse. It is a benefit-payment authority with no track record of helping people return to work.

Sickness benefit in Austria could now be paid much longer than for a year – even indefinitely – because rehabilitation benefit is not designed to be temporary even though eligibility will be reassessed regularly. Again, with regard to that particular feature, lessons from other countries are clear: open-ended sickness benefit with no support or activation leads to higher numbers of dependents and, ultimately, higher numbers of disability benefit claimants. Sweden's experience is a cautionary tale (OECD, 2009). Eventually the country abolished its unlimited sickness benefit to good effect (OECD, 2013b).

There is little likelihood that Austria's 2013 disability reform per se will see more rehabilitation and returns to work. By the time claimants

switch to rehabilitation benefit, they will have been out of work for a year and drifted away from the labour market. Intervention will come too late in most cases. Swifter intervention is critical if the reform is to do any good, with action first taken at an earlier point in sickness absence. The new fit2work service is a key move into that new territory (see Chapter 3).

Will there be more successful retraining?

One particularly critical element in the new legislation is that retraining for a new profession will be granted only if it is "appropriate and reasonable". "Appropriate" means that retraining must lead to labour market reintegration and be cost-effective – something that is difficult to assess. "Reasonable" requires retraining to be in line with a person's physical and psychological aptitudes and interests, their state of health, and level of educational attainment. The PIA determines eligibility, as it did in the past. Vocational training was also available under the old provisions, and with similarly restrictive criteria. The only difference was that the PIA provided it. But in both the old and new schemes, retraining is limited to people with an occupation in which they have professional training or experience.

The reform ushers in two changes that affect retraining. First, the PES assumes responsibility, being in principle well placed to offer jobseekers training. What will happen in practice, though, is that more people with health problems and partial work capacity will remain clients of the PES. The PES clientele will thus grow more disadvantaged, as happened a decade ago in Luxembourg in the wake of disability reform (Grubb, 2007), and as is happening now in several OECD countries like the United Kingdom (OECD, 2014a). The PES will therefore face a daunting task, which will require it and its caseworkers to understand far better the needs of jobseekers with chronic health conditions, particularly if they are common mental disorders.

Secondly, financial incentives will change. The PES has every interest in helping new clients back into work if only to reduce its own benefit costs. The PIA, by contrast, has less incentive than prior to reform, because the benefit costs will be covered by the PES for a longer period. Getting people into work is still in the PIA's interest, though, as it is obliged to reimburse the direct costs of retraining organised by the PES.

Decisions as to who is eligible for retraining will rest with the PIA, however, and criteria remain stringent. Retraining will be offered only

to people who stand a good chance of going back to work, something that is more difficult to predict for claimants with mental disorders. The PIA's response has been to put in place an assessment competence centre which evaluates people's state of health and whether they are apt for vocational rehabilitation and retraining.

One critical component missing from the 2013 disability benefit reform is a strategy for involving employers. They will, it is hoped, eventually offer jobs to claimants who have retrained or rehabilitated. Yet how the policy approach affects them has not been taken into account. Many PES offices have good networks of employers, which could help in placing retrained workers in the labour market. However, the PES has to improve its understanding of the needs of employers who agree to take on workers with chronic health conditions or partial disability.

Assessments will be crucial

Work capacity and benefit entitlement assessments by the PIA are critical to the performance of the benefit system. Similarly, the ability of the PIA's new competence centres to identify claimants who will benefit from retraining will be crucial to the success of the 2013 reform. It is too early to judge the PIA's assessment ability, as there are no studies available. Nor are there any studies that might explain the wide difference between regions in disability benefit grants, especially on the grounds of mental disorders.

The assessment process is the same across Austria and consists of three steps. General practitioners or psychiatrists assess claimants' remaining capacity to work or any functional restrictions caused by their medical condition. A further medical assessment is then conducted at a PIA regional office (by insurance doctors) and a decision is eventually taken by a central tripartite benefit committee which includes the social partners. The treating doctor's initial medical report determines to a very large extent any benefit entitlement, referral options, and rehabilitation potential, however, as the benefit committee follows doctors' recommendations in 95% of all cases.

The decision process applies an own-occupation principle that bars clients who are not trained in a particular occupation from vocational rehabilitation and retraining. It would appear that medical rehabilitation will not be restricted, however (Box 2.2).

Own-occupation assessment is both unfair and counterproductive and puts mentally unwell claimants at a twin disadvantage. First, they are more likely to be unskilled and, second, because they are further removed from the labour market, they are less likely to have followed a

normal employment path or an unbroken career. Mentally unwell claimants will seldom ever be entitled to vocational rehabilitation and retraining, which may account in part for the large increase in shares of disability claims for reasons of mental disorder. And it suggests that the 2013 disability benefit reform runs a high risk of failing.

Nor does own-occupation assessment seem effective in view of the poor labour market performance of those with rejected benefit claims. Rejecting claims alone solves no problems. Indeed, for some groups, earlier rehabilitation and training could have helped prevent later disability benefit claims – particularly among workers who have experienced broken careers and mental illness.

Box 2.2. **The own-occupation principle in Austria's disability scheme**

Own-occupation assessment means that skilled and unskilled workers are treated differently in the disability benefit scheme. Skilled workers are entitled to vocational rehabilitation and retraining. They may even be eligible for disability benefit if no longer able to perform in their own occupation (provided it accounts for most of their career). The PIA first explores the possibility of vocational rehabilitation for skilled workers before it decides to grant benefit.

Unskilled workers, on the other hand, are entitled only to benefit if they are no longer able to perform any job in the labour market. They are not entitled to vocational rehabilitation and retraining, but are entitled to medical rehabilitation. From the age of 57 (to be increased to 60), both skilled and unskilled workers are assessed against their main activity in the labour market over the previous 15 years. The own-occupation principle is applied most rigorously to civil servants who are assessed against their last activity, irrespective of age. That is also the *de facto* case for farmers.

The new reform does not abolish own-occupation assessment, but changes it into a criterion for assessing whether a claimant qualifies for retraining. Skilled workers are – where possible – retrained for a job that is equivalent to the one for which they are qualified in order to avoid benefit claims from those who are fit to work but no longer in their own occupation. This change will affect all white-collar workers in the private sector, though not civil servants or farmers.

This occupation-oriented way of assessing disability benefit entitlements was once the practice in many European countries, though most abolished them as long ago as the 1980s and 1990s (OECD, 2003). Some countries, by contrast, have never used the own-occupation principle or only to determine sickness benefit entitlement. But even they have increasingly modified it. Sweden, for example, now assesses entitlement to sickness benefit on the basis of a person's own job for the first 90 days, then against all jobs in the same company for another 90 days, and thereafter against all jobs in the labour market (OECD, 2010).

Source: OECD (2003), *Transforming Disability into Ability*, OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264158245-en; OECD (2010), *Sickness, Disability and Work: Breaking the Barriers*, OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264088856-en.

The new retraining benefit to which people are entitled if they are fit to work, even if is not in their own occupation, is partly an attempt to get around the own-occupation principle and involve the PES earlier, thereby improving the chances of placement. The change also means new sanctions for those who fail to meet the job-seeking criteria because retraining benefit, just like ordinary unemployment benefit, is suspended for six weeks in that event. Unskilled workers will not be adversely affected by, or benefit from, that change in any direct way. Indirectly, though, they stand to gain if reform improves PES caseworkers' awareness and knowledge of how best to help long-term unemployed jobseekers with (mental) health problems.

Work incentives could be an obstacle to reform

Work incentives are another issue that is seldom addressed in Austria in discussions as to how the disability benefit scheme may function and whether the new reform is likely to succeed. It is well known that disability benefits are much lower than old-age pensions – with the inference that disability benefit payments are low. However, to a very significant degree, the question is rather that pension entitlements are high – higher, indeed, than in most other OECD countries (OECD, 2014b).

From the point of view of the individual applying for a disability benefit because his/her state of health rules out any possibility of working, individual income replacement rates are far more relevant. Table 2.4 shows that the net replacement rate of a disability benefit is relatively high for both skilled and unskilled workers. It replaces 70%-80% of men's earnings and around 70% of women's (the lower percentage being the result of child-related career breaks and a lower average age of entry into disability benefit).

The replacement rates do not take other potential entitlements into account. Using more complex tax-benefit models (such as possible entitlements for housing benefit and social assistance top-up payments), OECD (2010) found that net replacement rates of disability benefit schemes tend to be very high among low-wage earners – over 100% in some countries – and significantly above the replacement rate of the disability benefit scheme alone. Many claimants with mental disorders earn wages below the average.

Work disincentives arising from the disability benefit scheme can only be offset if the PES steps up its activation of claimants in keeping with its strong work-oriented focus in general.

Table 2.4. **Disability benefits replace a high proportion of previous income**

Gross and net income replacement rates and average age on entering the disability benefit system, by age and occupational status, 2010

	Income replacement rates		Age when entering the system
	Gross	Net	(in years)
Men			
Total	60.8%	75.1%	52.6
Skilled profession	60.5%	75.6%	50.8
Un-/semiskilled profession	57.2%	71.0%	49.8
Eased access at older age	64.3%	78.6%	58.5
Women			
Total	56.9%	69.1%	48.3
Skilled profession	57.6%	70.8%	47.0
Un-/semiskilled profession	56.1%	67.2%	48.3
Eased access at older age	57.6%	69.6%	51.8

Source: Data provided by national authorities for the OECD Mental Health questionnaire.

StatLink http://dx.doi.org/10.1787/888933239451

The lack of a single responsible authority remains problematic

A key area in which the 2013 disability reform must deliver is institutional setup. It ushers in major changes in the roles assigned to the different authorities in order to prevent inactivity. However, with no single institution taking the lead, how the others will interface becomes a critical issue. The new system will require far better communication and collaboration between the different actors – particularly between the PIA and the PES over assessments and retraining, and between the health insurance bodies and the PIA in relation to medical treatment and medical rehabilitation.

The absence of an oversight authority poses a number of problems. Health insurance and the PES will be reimbursed for much of their new costs by the PIA, which means that there will, in effect, be two separate authorities – one for enforcement and another for benefit payment. The hope and the assumption is that the PES and health insurance bodies will feel it is incumbent on them to assume responsibility for clients with complex needs. Success of the 2013 reform will, at all times, require greater co-operation, particularly in assessment decisions, in order to prevent people from being shuttled back and forth between authorities.

The situation is further complicated by the structural setup of the Austrian system (see Chapter 1). The pronounced independence of the partly self-administered public bodies (like the PES, the PIA and the regional health insurance providers) makes it difficult to regulate co-operation and, more importantly, to get the incentives right for each actor. The steering group put in place to oversee the implementation of the 2013 disability benefit reform has a crucial role to play in linking the institutional stakeholders.

A vital ingredient for successful reform – and one that is lacking in Austria – is a case-managed approach of the kind used in other countries where a single authority has overarching responsibility for a wide range of clients and issues. Examples are the municipal job centres in Denmark, responsible for *all* labour market integration (OECD, 2013c). Case management can also operate *within* sectors in a more isolated way – both the PES and health insurance in Austria work with case managers, for example. But that requires strengthened links across sectors to ensure that handing clients over to another authority does not involve starting from scratch all over again.

Medical and vocational rehabilitation are ineffective

The rehabilitation-before-benefit principle is poorly enforced

Austria has long operated a principle of "rehabilitation before benefit payment". For those with their own occupation, the principle requires weighing up both medical and vocational rehabilitation options before deciding whether to grant benefit. For claimants who do not have their own profession, the principle applies only to medical rehabilitation. In reality, however, the principle suffers from two main shortcomings.

First, it often comes too late, as reflected in the poor labour market performance of those whose benefit claims are rejected. Second, the demands placed on claimants are minimal. Only since recently, in case of a temporary disability benefit grant a medical therapy or alcohol weaning could be requested but treatment is always voluntary.

The limited impact of the rehabilitation-before-benefit principle also stems from the fragmentation of the system. Both medical and vocational rehabilitation are, to a large extent, in the hands of the PIA. Medical rehabilitation often takes place during sick leave, while vocational rehabilitation is usually considered only after a health condition has stabilised – i.e. after a long time out of the labour market.

Moreover, the health insurance bodies and the PES have their own rehabilitation experts.

The introduction of fit2work (see Chapter 3) could afford the PIA a greater opportunity to start rehabilitation earlier – i.e. when people have been off work for 40 days yet still hold a job. How much this new fit2work service will really change the timing of rehabilitation, however, remains to be seen. So far, the PIA does not see employers as its clients and generally only acts at the request of an employee or, in most cases, a *former* employee. What is more, the PIA has no medical support to offer employers.

Little is known in Austria about the effectiveness of medical and vocational rehabilitation. No randomised controlled trials have ever been carried out, either for the mentally ill or for anyone else. However, a small-scale study in 2006 demonstrated that psychiatric rehabilitation does help the mentally unwell to retain their job. Of those employed when rehabilitation began, almost 60% were still employed one year later, while one-quarter had either applied for, or been granted, a disability benefit. Of those who were unemployed, more than one-third had found work a year later. As for those who were already classified as disability benefit claimants, some 15% were either employed or unemployed one year later (Table 2.5 and Chapter 4).

Even less is known in Austria about the effectiveness of vocational rehabilitation. Although it is currently voluntary and delivers good outcomes, that is because the typical client is 30 years old (as emphasised in OECD, 2003). Those good results do not, therefore, necessarily mean that vocational rehabilitation works for all. Older claimants – the vast majority of Austrian claimants – almost never apply for, or receive, vocational rehabilitation. The likelihood of it being effective if participation were to be mandatory and include older workers, too, is therefore unknown.

People with mental illness, who are often not entitled to vocational rehabilitation, face an additional hurdle in that rehabilitation sessions are typically organised on a full-time basis (all day and all week long) with limited flexibility.

Table 2.5. **sychiatric rehabilitation can improve job retention among the mentally unwell**

Labour force status at the start of medical rehabilitation and one year later

	Status one year after the onset of medical rehabilitation				
Status at onset	Employed	Unemployed	Benefit claimant	Benefit recipient	Total
Employed	65	18	11	17	114
Unemployed	21	14	9	15	61
Benefit claimant	11	11	22	29	73
Benefit recipient	2	3	4	81	91
Total	101	46	47	142	345
	Percentage distribution one year after the onset of medical rehabilitation				
Employed	57.0	15.8	9.6	14.9	100.0
Unemployed	34.4	23.0	14.8	24.6	100.0
Benefit claimant	15.1	15.1	30.1	39.7	100.0
Benefit recipient	2.2	3.3	4.4	89.0	100.0
Total	29.3	13.3	13.6	41.2	100.0

Source: Kollmann, I. and F. Fock-Putschi (2006), "Medizinische Rehabilitation psychisch Erkrankter in Österreich", Bericht über ein Pilotprojekt der PVA in den Jahren 2002-06.

StatLink http://dx.doi.org/10.1787/888933239465

Assessing the need for rehabilitation and training

The system's heavy reliance on the treating physician's assessment of whether a claimant stands to benefit from rehabilitation is problematic. GPs know little about rehabilitation, it not being a subject in the medical curriculum. Doctors tend to be advocates of their patients, often discouraging rather than encouraging rehabilitation. Proposed changes in the medical curriculum and the development of a specialisation for GPs (similar to other fields of specialisation) which could include more mental health focus could go a long way to improving the situation, albeit in the long run only (see Chapter 4). Occupational doctors could act as bridges between the health sector and the workplace. However, there is a shortage of such doctors and they have no formal role in the process (see Chapter 3). Nor is there any contact between occupational doctors and PIA insurance doctors.

The introduction of an entitlement to vocational rehabilitation for certain groups (i.e. those with a trained occupation), in 2011, improved the situation. The measure made it obligatory for the PIA to examine all patients in the eligible groups to determine their vocational rehabilitation potential. To better measure such potential, the PIA has developed a new tool, the so-called "career potential analysis". External

experts conduct the analyses and now share their results with the PES. Career potential analyses can include trial work of up to eight weeks in special assessment centres to identify an appropriate vocation. The decision to grant vocational rehabilitation is eventually taken by the PIA's special national rehabilitation committee.

One other issue is the often strict separation between medical and vocational rehabilitation, with the latter typically following the former even though they could, in theory, take place in parallel. However, when it comes to mental disorders, consecutive rehabilitation is not effective – the mentally unwell need integrated medical and vocational rehabilitation services. Only some rehabilitation providers have developed such services, one of which is the MODUS programme of the vocational education and rehabilitation centre BBRZ Reha.[3]

Reaching out to the PES and the health insurance

Ultimately, the 2013 disability reform aims to promote and enforce much closer co-operation between the PIA and the PES and, to a lesser degree, between the PIA and health insurance bodies, to prevent people setting their minds too quickly on permanent labour market exit.

Acting more promptly for people with remaining work capacity

In mid-2010, in anticipation of the disability reform, Austria ran a pilot scheme called the Health Road (Gesundheitsstraße) to eliminate multiple assessments by the PES and the PIA and test the efficacy of a single agency conducting assessments. Its target group was jobseekers registered with the PES who the PES felt might be unfit to work. For those clients, the PES itself had sought expert advice which sometimes ran counter to later assessments by the PIA. The result were frequently: very unclear situations for clients, unnecessarily long assessment procedures and, in most cases, the worst outcomes which saw many clients go without proper support and seldom return to work.

The final evaluation report on the Health Road, however, found mixed results (Hausegger et al., 2012). People assessed by the Health Road had a different outlook to those who applied directly for a disability benefit. They were more in touch with the labour market and more likely to see work as a viable prospect. Indeed, only 27% of them were unable to imagine working, compared to 69% of disability benefit claimants. Yet, even among the Health Road clients with a confirmed capacity to work, initial results suggested that those who worked or got a place on a PES training scheme in the following year were

exceptions. Significantly, 35% of the claimants that the Health Road assessed suffered from mental illness or behavioural problems. Health Road found a higher proportion of them temporarily unable to work (one-third) than in other groups (one-fifth). And many of them were very likely to claim a disability benefit subsequently.

Since the disability reform came into force, the PES has had to organise occupational assessments of jobseekers with health problems at an earlier stage and the PES and the PIA have had to mutually acknowledge each other's assessments. Furthermore, the PIA now has to make its medical reports available to the PES in the event of a disability benefit application being denied. This is a major improvement on the situation that prevailed until just a few years ago, but the reform process cannot end there. Assessment of the capacity to work needs to be followed by swift identification of the person's resources and immediate rehabilitation and training measures, whenever necessary.

Early intervention using health insurance knowledge

Early intervention is critical to all actors. Any action that comes at the time of a disability benefit claim or an application to the PIA for medical or vocational rehabilitation will almost always be too late. It is critical to intervene in the early phases of sick leave, when many workers still have an employment contract, or even earlier – before they begin long-lasting sick leaves.

The need for early intervention makes health insurance providers important players – more important than Austria's social security system currently acknowledges. There is significant evidence that people who are at risk of a health-related labour market exit could be identified early by their health insurers. Both sick workers' use of medication and the number of days of sick leave they take before claiming disability benefit have risen many years in advance. According to Leoni (2011), as early as seven years before the disability benefit claim the incidence of sick leave has already risen by 80%. And the closer to the moment workers actually submit their claims, the more frequent their sickness absences are.

Long-term sick leave is the best predictor of later disability benefit claims: sick leave of over six weeks (six months) leads to a disability benefit claim seven years later with a likelihood of 25% (50%). Sick leaves caused by mental illness and overlapping with unemployment are most likely to culminate in permanent labour market exit.

All the above facts and figures easily available to health insurance providers could be used to identify people who may need medical rehabilitation and maybe vocational rehabilitation and training, too.

Early identification and intervention with a strong rehabilitation focus and, where needed, career change counselling can prevent labour market exits. To that end, the Austrian practice of employers and employees not discussing matters of sickness must cease, the narrow room for manoeuvre arising from doctor-patient confidentiality must be addressed, and health insurers must play a greater role – together with employers – in monitoring and managing sickness absence (Chapter 3).

Enabling the PES to address its clients' mental health issues

PES caseworkers in Austria are, in principle, well aware that mental ill-health is particularly relevant to the unemployed who are difficult to place. However, addressing mental health issues is not a core activity of the PES, nor is linking up with the health insurance providers and the medical rehabilitation authorities an objective.

The (long-term) unemployed are another vulnerable group

The high prevalence of poor mental health among the unemployed is one indication that it is a labour market barrier that needs to be addressed. Administrative data on sick leave and sick days off are another way of measuring the health-related disadvantages that hamper the unemployed. Employed and unemployed workers are both entitled to sickness benefit and subject to almost identical sick-pay regulations. Aggregate statistics for the year 2008 show that the unemployed spend almost 9% of their time on sick leave, compared with an average of 3.4% among people in work (Leoni, 2010a). Only about half of that difference is thought to be down to a selection effect, because people with poorer health are more likely to become unemployed. The other half is likely to stem from behavioural problems and can be addressed by targeted intervention.

Unemployed people are much more prone to long sick leaves than people in work – 19 days *per annum* versus 10 on average. They also spend more time in hospital – 4 days compared to 1.6 (Leoni, 2010b). Poor mental health is a more frequent cause of illness among the unemployed – it accounts for around 15% of all sick days against less than 5% among people with a job. Among the long-term jobless, the share rises to almost 20%. And it should be borne in mind that mental illness goes widely underreported in Austria as a cause of sickness absence (see Chapter 3).

There are two more striking observations to be made. The first is that excessive sick time is especially high among unemployed people in the 35-54 year-old age group, while the difference is slight when it comes to young and older workers. The second point is that excessive time off for sickness has increased dramatically and constantly since 1990 when the jobless showed only a slightly higher sickness incidence than their employed peers. Although little is known of the reasons behind the widening of the sickness gap, it is clear that policy will have to respond to the growing health challenge facing the unemployed and the high incidence of poor mental ill-health that affects them.

Mental health problems are neither identified nor addressed

The chief task of Austria's public employment service (which operates through local offices) is to find work for the unemployed who are job-ready and to prepare those who are not for the labour market.[4] The PES determines job-readiness not by any profiling tool but through interviews with jobseekers. So it generally remains unaware of any problems that interviewees do not disclose. It has made no attempt to date to systematically screen jobseekers for mental health problems and has no tools for doing so.

The PES must not only refocus, it must also introduce new instruments and processes if it is to be adequate to the task of helping jobseekers with mental health problems into work. That is no easy task. Many jobseekers with non-disclosed mental disorders may initially appear highly motivated. And it can take any number of failed job placements before a caseworker discovers any work barriers stemming from mental ill-health. Disclosed mental illness, on the other hand, is likely to result in long-lasting sick leave or job-search exemptions.

The PES seldom offers its clients any support until they are considered cured and, by the same token, job-ready – on returning from successful medical rehabilitation, for example. There is no contact between PES caseworkers and their clients during periods of sickness which, in cases of common mental disorders arising from burnout, for example, can last several months. Waiting until chronic mental illnesses have been cured may well be detrimental to the people as such illnesses may not be truly curable. They call for early employment intervention.

Jobseekers in Austria classified as job-ready will initially stay in job placement for a period of three to four months. Only thereafter, or if they are not deemed job-ready, does counselling kick in. There are also particular target groups, such as women returning from a long-term child care, who benefit from more attention early on. Clients with

mental health issues could, in principle, become a target group. That, however, would require rethinking the role of the PES, as current operating methods and available tools would not be fit for purpose.

The means for addressing mental health issues are limited

Local employment agencies are too poorly equipped and resourced to cope with their clients' mental health issues. They have very limited psychological expertise and the few psychologists focus only on diagnosis, not therapy. There are also few special measures available. Job placement and counselling are built on a mainstream philosophy.

Some mainstream tools actually have considerable potential for jobseekers with common mental illness. Flexible apprenticeships, for example, which may be part-time or run over a longer-than-usual number of years, can often be useful for clients who suffer from mental ill-health or have psychosocial problems. The PES can also provide mentally unwell employees who are still in work with requalification services to help them take up another job in the same company. Again, such services have potential for workers with mental health problems who disclose their condition to the PES.

Reaching out to clients who do not attend the obligatory meetings with their employment counsellor is also considered effective – particularly as many such clients suffer from mental ill-health. However, outreach is resource-intensive and therefore rare in practice.

Jobseekers whose needs the PES particularly struggles to meet are those who have a non-diagnosed, untreated mental illness they are unwilling to admit. Although diagnostic work trial training can actually yield a form of "diagnosis", the PES can do little for such people – other than stopping their unemployment benefit if, or as long as, they refuse any in-depth assessment by the PIA. Such jobseekers typically give rise to very costly casework over many years, but rarely achieve sustainable employment outcomes.

Clients who accept their mental health problem but discontinue psychotherapy treatment may not be any easier to deal with. The lack of integrated health and work intervention takes them down a dead end. The PES has no tools or knowledge at hand to help them – it can do little other than encourage them to seek help from the health system. Another group which behaves in the opposite manner – seeking treatment but failing to co-operate with the PES – is equally troublesome. Strict activation and benefit sanctions may be effective in such instances.

Among the most helpful tools available to Austria's PES is career potential analysis, which the PIA has rolled out nationwide and for which it pays. It helps test jobseekers' interests, levels of motivation, and actual work capacity, all of which is used as a base for subsequent PES counselling. But the PES needs more: more case management to address previous or current work problems, more counselling time, more therapeutic support for mental illness, and more coaching for adults (along the lines of the Youth Coaching scheme; see Chapter 5).

New challenges through the means-tested minimum income

With the reform and harmonisation of the social assistance scheme, fully implemented across Austria in 2011, regional and local PES offices face new challenges. One key element of the social assistance reform – allowances are now called "means-tested minimum income" (BMS) instead of "social assistance" – is a stronger focus on helping benefit recipients into the labour market. Accordingly, there is a more binding obligation on BMS clients to offer their labour and register with their regional employment office[5] In turn, the PES had to contend with growing numbers of BMS recipients in its caseload. Many such clients are formally able to work but not job-ready. The ability of the PES to help them is critical.[6]

Research has shown that BMS recipients differ from other PES clients, be they the shorter-term unemployed on unemployment insurance benefit or the long-term jobless who receive a slightly reduced and means-tested unemployment benefit. The key difference is that BMS recipients are at a much greater remove from the labour market and that many of them grapple with health problems. One-third have had no spells of work in the previous five years; a very high share did not finish school; and half of all BMS recipients have health problems, chiefly mental health problems (Bergmann et al., 2013; Riesenfelder et al., 2011).

Because such clients are not job-ready, tackling their problems and labour market barriers takes precedence over realistic job placement. Although the Austrian PES is, in principle, well-placed for that task, it is not in practice ready to shoulder such a responsibility and deliver the right support fast to clients who are as difficult to place as BMS claimants. Its ill-preparedness is a matter partly of resources and partly of time, as appropriate tools have yet to be developed. Although specialised providers across the country do operate some innovative and typically small-scale schemes (Box 2.4), the PES has yet to purchase any of those on a larger scale.

Box 2.4. **Promising interventions for bringing difficult-to-place clients with mental health problems into or closer to the labour market**

Supported Employment (*Arbeitsassistenz*). Austria introduced the Supported Employment scheme about 30 years ago. The scheme is very flexible and, though not limited in time, it is restricted to people who have a legally registered disability (which reduces by at least 50% their ability to function) and have been assessed by a doctor from a local service office of the Ministry of Social Affairs. Although the disability may be a mental disorder like severe depression, the vast majority of the mentally unwell do not seek officially registered "tagging". Supported Employment is therefore used chiefly for people who suffer from a severe physical disability or mental retardation, and only rarely for PES clients. The share of Supported Employment users with a mental disorder is around 30%.

Check for Chances (C4C): C4C is a programme targeted at unemployed claimants who have been health assessed by the PIA's Health Road unit, i.e. people who have had their work capacity confirmed, but whose health problems continue to be a barrier. One-quarter of C4C clients suffer from mental illness, while half of them report significant psychological distress or substance abuse issues, and half have been unemployed for more than three years. Helping them into or back to work will typically be in steps: psychiatric rehabilitation, followed by work in the secondary sector of the labour market, then on into the primary sector.

Step by Step (*Schritt für Schritt*): This is a low-threshold measure with intense counselling that operates in four of the nine Austrian regions. It is targeted predominantly at clients whom PIA's Health Road has assessed as mentally ill and who have received support from C4C, though it also targets people with rejected disability benefit claims. Step by Step courses are group interventions that last 23 weeks, offering condition management services to improve health, fostering clients' personal potential, and providing work training in line with personal interests. The ultimate aim is to start work or training.

Step 2 Job: Step 2 Job is a programme for the long-term unemployed who are social assistance recipients. It can last for up to one year and is built on individually tailored case management. Programmes may, depending on needs, include an assessment of a person's potential, social work support, and interacting with doctors and psychologists.

MODUS: MODUS is a modular programme for people with a psychiatric diagnosis or who suffer from mental ill-health and are long-term sick, unemployed, or on a temporary disability benefit. The aim of the scheme, which can last up to 15 months, is to provide clients with individually tailored support (e.g. condition management, support in finding treatment, practical training) during the transition from medical to vocational rehabilitation, and to prepare them for the labour market or training.

IMBUS: IMBUS is a scheme for people with mental or co-morbid mental and physical health problems who are unemployed or in receipt of temporary disability benefit. It seeks to stabilise people through condition management and gradually prepare them for the demands of the labour market by developing an individual vocational rehabilitation plan. IMBUS can last up to 16 weeks and is often followed by work training courses that last up to 30 weeks.

Problems also arise as a result of trying to fit new facts and trends into existing legal frameworks. The Austrian PES, for example, decides whether a client needs more intense support and counselling on the basis of how long they have been registered. New BMS clients have, however, often been away from the labour market for many years without ever having registered with the PES. The PES would not, therefore, identify them as a major risk group until much later and often too late.

The PES needs more specialists to be able to attend to its BMS clients and give them case-managed support before it grants them a place in a scheme to help them into work. The specialised knowledge the PES requires to that end must include understanding of mental health and how to get the right treatment for mental illness. It will often be necessary to ease clients into the open labour market gradually, starting with only a few hours, or in the secondary sector in a social market company, and ensuring on-going support from a social worker.[7]

BMS clients still account for a minority of all PES clients and are not a priority group. The main focus is still on those who receive unemployment benefit. That must change.

Round-up and recommendations

The Austrian benefit system insures against a range of risks in ways that differ substantially in their activation requirements and provision of return-to-work support. As a consequence, people with chronic health problems on sick leave or disability benefit face a situation very different from their peers who are on unemployment benefit – a situation that is hardly ideal in view of:

- the high prevalence of ill-health, especially mental ill-health, among claimants of unemployment benefit and social assistance
- the high incidence of sick leave among the unemployed, which may exempt them from looking for a job
- the large number of people who are partially able to work and are on sickness and disability benefits.

To address those issues, Austria has introduced two benefit reforms that go in the same direction. The 2011 social assistance reform has made it much more binding on many more benefit claimants to seek work and register with the public employment service. Under the provisions of the disability reform, introduced three years later and still

being implemented, claimants previously entitled to disability benefit must now register as jobseekers unless they are fully and permanently unable to work. The upshot of the two reforms is that a much larger, and growing, number of people out of work must sign on with the PES and actively look for a job.

The eventual effect of the reforms remains to be seen. The extension of the PES's employment activation framework to many more of the jobless has significantly changed the make-up of PES clients. As in several other OECD countries, they now include a growing share of jobseekers with mental and physical health issues that could be an obstacle to their finding work. If the reforms are to be successful, therefore, they must be rigorously implemented.

Several actors – the PES, the PIA, and the health insurance providers – are facing new challenges. Each institution will need to improve its own capacity to address new issues and all must integrate their support provisions far more strongly.

The benefit system is still using a narrow, inflexible approach built on practices that are detrimental to the better labour market integration of people who are mentally unwell and – to compound matters – more frequently low-skilled than other groups. Those practices are:

- an over-focus on age as a predictor of work capacity
- interventions that came too late given the early onset of mental illness and the fragile work histories of many sufferers
- waiting until the mentally ill are "cured" before using any active labour market tools
- the focus on own occupations, which discriminates against low-skilled workers
- the strongly selective admission criteria for vocational rehabilitation programmes and the tight entitlement restrictions placed on participants
- the poor provision of partial (sickness) benefit.

All of the above suggests that it is not yet understood that mental health may be *the* key challenge of the future.

Address the rise in disability benefits with a mental disorder

- *Expand the knowledge base*. Little is known about the reasons for the wide regional differences in disability benefit applications and

awards on the grounds of mental ill-health. There is a need for more research, which should include field trials with blind double assessments within and across regions. Nor is much known about the characteristics of mentally unwell claimants or their pathways in and out of the benefit system.

- *Improve benefit assessments*. Assessments are geared towards determining benefit eligibility. They overlook how to help claimants back to work, especially those with mental illness. To rectify that imbalance, the response must include greater resources for the PIA's new "competence assessment centres" and better training for insurance doctors and assessors in order to produce uniform assessment results. As for treating physicians, they should have less say indecisions to grant rehabilitation and training or not. The knowledge base for assessment decisions should be improved by compiling individual resource profiles for all claimants, as is done in Denmark. They would help to make better informed assessments of people's labour market potential.

- *Address inequality in access to disability benefits.* Consideration should be given to abolishing own-occupation assessments and tightening disability benefit eligibility criteria for the over-57s. Own-occupation assessments penalise unskilled workers by excluding them from retraining. They disproportionately affect mentally ill claimants, many of whom are unskilled. Lax disability benefit eligibility criteria for older workers will lead to their being shunted off return-to-work support, perpetuate acceptance of early retirement through the disability scheme, and become a growing obstacle to improving older workers' employment rates when early retirement options are all closed.

- *Prevent unsuccessful disability benefit claims.* Austria's very high rate of benefit claim denials is bad policy, because it leaves to their own devices a large number of people who generally never return to work. Every effort has to be made to prevent claims from people who are not eligible by identifying their needs and providing support earlier. The 2013 disability reform must address and solve that challenge (see below). In addition, the PIA and the PES should target unsuccessful benefit claimants in order to prevent repeat applications and definitive labour market exits.

Implement the 2013 disability benefit reform rigorously

- *Effectively support rehabilitation benefit recipients.* This new benefit could easily turn into a long-term transition payment on the

way to permanent inactivity – just like the erstwhile temporary disability benefit was. It is critically important to address the mental health and work-related needs of rehabilitation benefit recipients quickly, effectively. It must be done in an integrated manner, bringing together the PES, PIA and health insurance providers. And it must be clear to claimants that rehabilitation benefit is not a stepping stone to permanent inactivity.

- *Effectively support retraining benefit recipients.* This new benefit, too, can easily turn into costly, long-term payment for the long-term unemployed. It is critical that the PES should activate this group swiftly and provide effective, timely job-search support.

- *Make interventions more flexible.* Interventions need to be flexible to ensure that the mentally unwell enjoy equal access. Medical and vocational interventions, for example, should be provided on a part-time basis and in half-day sessions. Medical and vocational rehabilitation should be more closely linked and provided in parallel whenever necessary, not consecutively as is usually the case today. It is also important that clients may not choose to evade support measures – avoidant behaviour is frequent in certain mental illnesses.

- *Monitor the responsibility structure.* The lack of a principal lead authority could endanger the success of reform. There should be strict monitoring how the institutions whose roles have been changed by the reform live up to those new roles and co-operate with each other. It is critical that their procedures should be transparent, that they maintain close links, and hand over clients to each other efficiently. An oversight authority may eventually have to be put in place to ensure the continuous case management of clients. The PES would probably be best placed to assume such a role. Decisions taken by the PIA as to the provision of rehabilitation and retraining must be monitored to ensure that people do not retire too early and easily.

- *Successfully expand reform to older workers.* Initially, the 2013 disability benefit reform was to apply only to the under-50s. When it is gradually expanded to the 50-64 age group, the same rigorous implementation will be required, especially as Austria has a strong culture of early retirement. It is particularly important that the older age groups be offered the same medical and vocational rehabilitation opportunities.

- *Extend the system to the entire labour force.* The reform affects only blue- and white-collar workers in the private sector. This creates inequality. In view of the high disability risks run by farmers and civil servants (at federal, state and local levels), reform should be extended to the public sector and ways sought to bring in farmers on a comparable footing.

Help health insurance act quickly and effectively

- *Transform sickness benefit into a more active benefit scheme.* Sickness benefit in Austria is an inactive payment, and health insurance takes a very passive role. As in other OECD countries, the sickness benefit scheme should become more closely oriented to returns to work. To that end, not only should health insurance monitor benefit misuse, it should better monitor the entire sickness benefit process as part of a new sickness management culture in Austrian workplaces (see Chapter 3).

- *Monitor continuously and intervene swiftly.* Research shows that sick leaves begin to reach much higher levels at least a decade before workers exit the labour market. Clear indicators should be defined to identify high-risk groups early and provide integrated health and work support quickly. Target groups should include workers whose sick leave is repeatedly above the industry-specific average, of long duration, or caused by mental illness. The unemployed who are sick are also a risk group. For all risk groups, effective treatment and earlier medical rehabilitation is important.

- *Develop guidelines and co-operate with doctors.* In order to monitor the sickness process effectively, health insurance should co-operate with treating doctors, develop guidelines for evidence-based sickness absence certificates together with medical associations, and support treating doctors in their role as gate keepers to the benefit system.

- *Equip health insurance with tools and knowledge.* Health insurance staff comprises controlling doctors and benefit administrators. Health insurance providers must have qualified staff able to deal with people in need of swift return-to-work support. Investing in caseworkers will pay off. Improving links with the PES will also be important for ensuring integrated medical and vocational interventions.

- *Offer more flexible sickness benefit.* In Austria, workers can only be fully fit or 100% sick. Such a perception of sickness and health

does not fit with most mental illnesses and contributes to longer-than-necessary sickness absence. Other OECD countries are increasingly promoting partial or graded sick leave to promote faster returns to work. While partial sick leave as such may invite misuse, the option of a partial return after a few weeks of full absence would stimulate an earlier, and possibly more sustainable, return to the workplace.

- *Expand the knowledge base*. Little is known about the reasons for the rapid increase in sickness absence among the unemployed over the past 25 years. The reasons and the characteristics of this group need to be better understood, in order to ensure an adequate policy response.

Empower the PES in addressing frequent mental health problems

- *Expand the knowledge base.* Very little is known in Austria about jobseekers' states of health or the prevalence of mental ill-health. Research on the incidence, type, and severity of clients' mental health problems and the impact they have on returns to work is urgently needed. It should cover both the short- and long-term unemployed.

- *Improve the mental health expertise of the PES.* In view of the high prevalence of mental illness among unemployed people, the PES needs more knowledge of mental illnesses and the labour market barrier they cause. PES caseworkers need basic mental health training and, as in other countries, there should be enough psychological expertise in all employment offices to provide, when necessary, low-threshold counselling and therapeutic support.

- *Refocus on more disadvantaged clients.* Recent disability benefit and social assistance reform has swollen the number of clients with partial health impairments who have to register with the PES and comply with its relatively strict activation regime. In response, the PES needs to develop its ability to handle such clients, their growing number, and their health-related work barriers. That effort must include more time for counselling and case management.

- *Identify and address mental health-related work needs.* The PES may have to reconsider its target groups. People with mental health problems are a group at high risk of long-term unemployment, if their health needs remain unaddressed. To bring integrated support to bear, the PES has to identify needs more systematically and rapidly. Approved profiling tools – to screen clients for mental ill

health, for instance – could help identify those at risk. PES caseworkers need guidelines on when to use such screening tools, how to handle confidentiality issues, and what to do when a mental health problem is detected.

- *Improve procedures for other high-risk groups.* The PES should put in place a systematic casework approach to address the needs the social assistance clients who are now obliged to register with the PES. Many of them face additional barriers, often related to mental illness, and have been out of the labour market for many years. Those who have been temporarily dispensed from activation and job-search support should not be left out. It is important that the PES sees that they still attend regular job-focussed interviews, and that it continues to provide support services and to collaborate with treating physicians.

- *Develop appropriate tools and procedures for the PES.* If used regularly, a number of mainstream tools have considerable potential for helping mentally unwell clients into or back into work. They include flexible apprenticeships, for example, and active outreach to people missing their appointments. All tools for clients with health and complex barriers to work should, where necessary, provide on-going support in order to achieve sustainable employment outcomes. The PES should foster closer ties with a range of other actors to reach people who need its support. Actors include schools, for example, with which the PES should work more closely to help young people with mental health problems in their transition to employment. The PES should also interact more closely with rehabilitation centres to ensure customers are handed over smoothly and rehabilitation services are better integrated.

- *Strengthen ties with employers.* As the average state of health of its clients worsens and the problems of its many new ones grow more complex, the PES must strengthen its ties with employers in order to improve its clients' prospects of finding work. It may have to consider developing new demand-side instruments to stimulate hiring and boost job retention. Employers also need support – like coaching for supervisors – to help them retain workers. The PES could strengthen its workplace interventions to raise employer awareness of mental ill-health and help them understand, for example, that workers who struggle with social interaction should not work in teams and those who suffer from depression-related fatigue and have trouble concentrating should be able to take more breaks.

Notes

1. The younger age of entry into disability benefit also helps explain why the average retirement age in Austria has not fallen much in the past decade, despite significant pension reforms that restricted early retirement benefits. The pension reforms have generated large increases of 10-15 percentage points in labour force participation rates among 55-64 year-old. However, later retirement in that age group has been almost entirely cancelled out by the rise in labour market exits via disability benefit among the under-50s (Zweimüller and Staubli, 2012).

2. Austrian disability benefit still makes extensive use of the own-occupation principle which brings with it all kinds of problems, such as inequality of treatment and opportunity between those who have and do not have a profession in which they have trained or long worked. The principle, however, looks set to be maintained.

3. www.bbrz.at/fileadmin/user_upload/Produkblaetter/Reha-Kombination/Kaernten/REHA-Kombi_Modus-Villach.pdf (accessed 1 June 2015).

4. In addition to job placement, the PES in Austria has two other roles: to provide support services and counselling to employers and to provide occupational and labour market information to the entire labour force.

5. Today, about one in five BMS recipients living in private households is registered with the PES. That share is likely to increase considerably.

6. As a consequence, BMS recipients also have to contend with the PES's stricter activation and sanction regime. Initial evidence, however, suggests that sanctions have not been widely used, so far, and affect only between 5% and 10% of BMS recipients (Bergmann et al., 2013).

7. Social market companies are known as "socio-economic" companies in Austria. They are regular companies which receive special state subsidies that allow them to hire workers with reduced capacity to work for periods of up to nine months.

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Chapter 3

Preventing labour market exit at Austrian workplaces

The workplace plays an important role in both workers' productivity and sickness absence and disability. Poor working conditions may negatively affect mental health, but good management and professional support can help prevent – early and effectively – the exclusion of workers with mental health problems from the workplace. This chapter considers evidence of work-related stress in Austria, working conditions, and the absenteeism and presenteeism of employees with mental health problems. It also discusses the growing focus on psychosocial work issues and the recent reform of the Labour Protection Act. The chapter highlights some sickness management regulations and sick-leave interventions.

The workplace is a particularly important area in which policy can tackle exclusion that stems from mental health, in several ways.

- It affects mental health both adversely and positively. Disorders can be triggered or heightened by poor working conditions like the undue stress related to high demands and low reward, the pressure of time and job insecurity (OECD, 2012). Similarly, good working conditions, competent managers, and supportive co-workers bolster psychological well-being. The conduct of line managers and colleagues is crucial in helping mentally unwell workers keep their jobs or resume them after sick leave.
- Being in employment has a psychologically protective effect – not only does it provide a secure income, it contributes to self-esteem and enhances social participation and identity.
- It is more cost-effective to support job retention than to invest in re-integration of people who have been away from the labour market for a long time. Early intervention in the workplace is therefore crucial to averting long-term sick leave and disability claims.

The importance of the workplace in the prevention of mental ill-health, early intervention, and returns to work are thrown into relief by the OECD-wide increases over recent decades in the productivity losses, sickness absences, disability benefit claims, and self-reported work-related stress that originate in mental health problems (OECD, 2012). Yet, at the same time, the prevalence of mental disorders in the population as a whole has remained stable (Richter et al., 2008).

The growing exclusion from the labour market of people with mental health issues happens despite a growing awareness in general and better treatment of psychological disorders; better awareness and treatment have yet to translate into better workplace management.

Once an opportunity, the focus on work-related stress could become a problem

The employment rate has risen steadily in Austria. There is generally high satisfaction with working conditions, greater job security than the OECD average, strong rates of employment tenure and considerable contentment with the work-life balance. Moreover, the effective retirement age is among the lowest in the OECD (OECD, 2013a). Nevertheless, work-related stress and psychosocial risk factors in the workplace have become a rapidly emerging political issue in the

country. Structural changes to the labour market – its expanding service sector, greater competitiveness and more flexible production – are considered to be related to increasingly demanding working conditions that have had repercussions on work-related stress (Biffl et al., 2012).

Psychological job strain is on the agenda

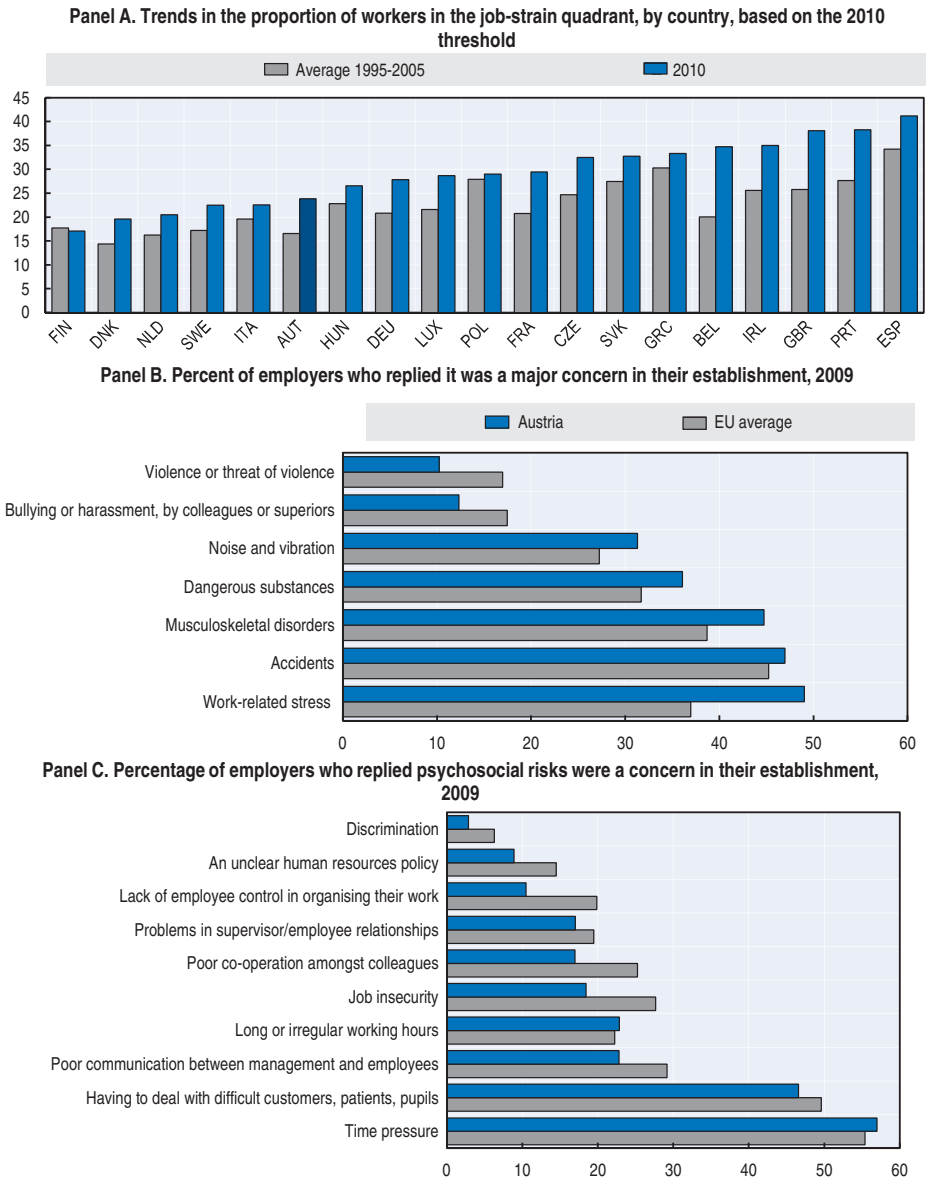
Data from the European Working Conditions Survey (EWCS) show that, as in most European countries, the share of employees who feel "job strain" – low workplace autonomy and high demands – climbed in Austria between the mid-1990s and 2010 (Figure 3.1, Panel A). Job strain can cause stress-related mental health problems (Karasek and Theorell, 1990), especially among low-skilled workers. The share of unskilled workers, machine operators and service workers who experience stressful working conditions is around twice as high as among technicians and professionals (OECD, 2012).

The growing public attention to job strain is reflected in the employer survey of the European Agency for Safety and Health at Work (EU-OSHA).[1] Around half of all Austrian enterprises perceive work-related stress as a major concern, a share considerably above the EU average (Figure 3.1, Panel B). As for psychosocial risk factors in the workplace, Austrian employers seldom care about discrimination, poor relationships between management and employees, weak team spirit, long and irregular working hours, or job insecurity. However, more than half of all employers are concerned about working under the pressure of time, consistent with the close correlation found between time pressure and psychological strain (Figure 3.1, Panel C).

The prevailing job-strain focus is not supported by evidence

The Austrian Work Climate Index, which is regarded as the most valid source of job satisfaction data in Austria (Eichmann et al., 2010) shows results that contrast with those of the EWCS and EU-OSHA. It finds that, on average, physical and psychological job strain both fell substantially between 1997 and 2013 (Figure 3.2). Psychological strain, measured by two questions on perceived time pressure and psychologically demanding work, declined by roughly one-third, from about 45% to less than 30% of the workforce. Generally, satisfaction with most aspects of life rose over the same period.

Figure 3.1. **Although Austria ranks low in job strain, work-related stress has become a major concern**



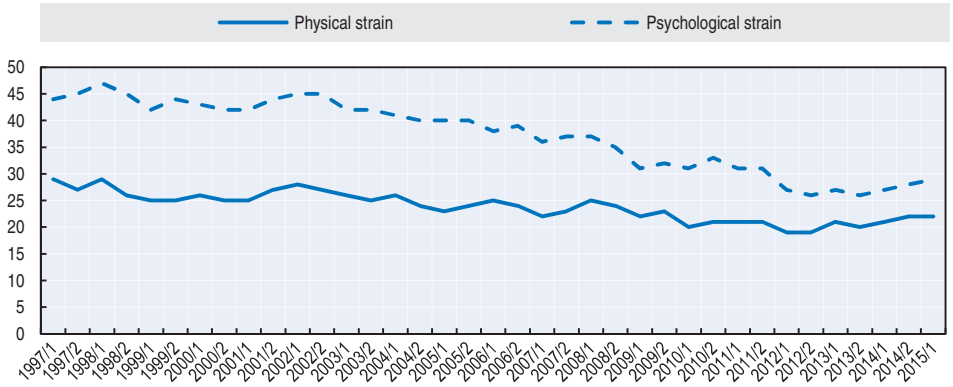
Source: Panel A: OECD calculations based on European Working Conditions Survey (EWCS) 1990-2010; Panels B and C: OECD calculations based on the European Survey of Enterprises on New and Emerging Risks (ESENER) of the European Agency for Safety and Health at Work.

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The significant drop in reported psychological job strain in the past 15 years holds for blue- and white-collar workers, the unskilled and skilled, professionals, managers and civil servants across all economic sectors (Table 3.1).

Figure 3.2. **Perceived work stress is high but has fallen since 1997**

Indices of perceived physical and psychological work stress in the Austrian working population, 1997-2015



Note: The work-related indicator "Psychological strain" is based on the following question: "How much do you feel stressed in your job by: a) time pressure; b) psychologically straining work". Both questions can be answered on a scale ranging from "1" (heavy strain) to "5" (no strain at all). The resulting values are transformed into a scale ranging from 0 (no strain of either kind) to 100 (heavy strain of both kinds).

Source: Data from the Austrian Work Climate Index of the Upper Austria Chamber of Labour, http://ooe.arbeiterkammer.at/beratung/arbeitundgesundheit/arbeitsklima/Arbeitsklima_Index_Datenbank.html (accessed 1 June 2015).

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Perceived psychological work stress increases with the seriousness of the employee's mental health condition. Additional data from the Occupational Health Monitor show that time pressure, psychologically stressful work, and the risk of accidents and injuries are the three greatest work sources of strain among employees with mental health issues. The situation seems to have improved in recent years, however (Figure 3.3). Perceived workplace stress was higher in 2008 than in 2012 across all sectors and professions and regardless of the seriousness of psychological disorders.

Table 3.1. **Austrian workers report less psychological work stress today than 15 years ago in all sectors and professions**

Indices of perceived psychological work stress in the Austrian working population, by occupational groups and economic sector

		Average of earliest quarters	Average of latest quarters
By vocation			
	Unskilled workers	41.3	30.0
	Employees	37.3	23.3
	Skilled workers	42.5	27.0
	Professionals, managers	49.0	26.5
	Civil servants	49.3	35.3
By sector			
	Industry	42.5	29.0
	Transport	48.5	28.5
	Construction	47.3	28.0
	Education	48.8	37.3
	Finances	36.8	23.5
	Retail	41.0	27.7
	Public administration	42.3	25.5
	Tourism	39.0	27.0
	Health care	50.0	36.0
	All	43.5	27.5

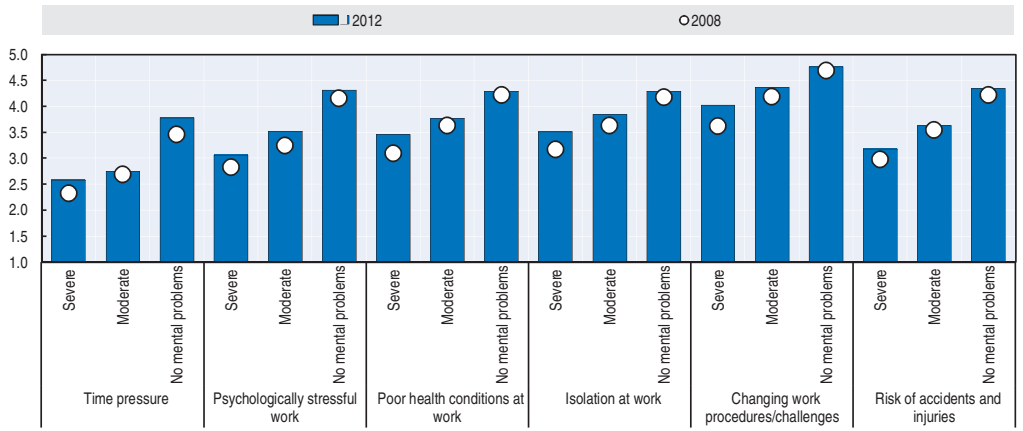
Note: The early period refers to the following averaged quarters: 1st and 3rd 1997, 2nd and 4th 1988 for vocation data and to 4th 1988, 2nd and 4th 1999 and 2nd 2000 quarters for sector data. The latest period refers to quarters: 4th 2013, 2nd and 4th 2014 and 2nd 2015.

Source: Data from the Austrian Work Climate Index (Arbeitsklima Index) of the Upper Austria Chamber of Labour (Arbeitskammer Oberösterreich), http://ooe.arbeiterkammer.at/beratung/arbeitundgesundheit/arbeitsklima/Arbeitsklima_Index_Datenbank.html (accessed 1 June 2015).

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Figure 3.3. **Employees with mental ill-health perceive higher work stress than other workers**

Perceived psychological work stress in the Austrian working population by mental disorder, 2008-12



Note: The Austrian Occupational Health Monitor uses nine questions to measure the mental health condition of employees (with a focus on exhaustion, low energy and self-confidence, and anxiety). Every question can be answered on a scale ranging from 1 ("very true") to 5 ("not true at all") which gives every employee a total value of between 9 and 45. Analogous to the methodology used in *Sick on the Job?* (OECD, 2012), the Austrian Upper Chamber of Workers calculated the 5% of the employees with the highest values (here "severe mental disorder"), the next highest 15% ("moderate mental disorder") and the remaining 80% ("no disorder"). Perceived strain (the y axis) goes from 1 ("heavy strain") to 5 ("no strain at all").

Source: OECD calculations based on data provided by the Austrian Upper Chamber of Workers.

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Renewed focus on job strain but concrete support lags behind

While work-related stress might not have increased over recent decades, around 30% of the working population experiences significant stress. As a result of growing awareness among the social partners and national authorities of mental health problems in the workplace, the new Labour Protection Act became law on 1 January 2013. It compels employers to systematically evaluate and document psychological strain in the workplace, implement measures in the event of problems, and evaluate the effectiveness of those measures (Box 3.1). Although the labour inspectorate does not prescribe which assessment instruments enterprises

should use, it offers support in choosing the right one and sets out the criteria that instruments should meet (they must be objective, reliable and valid; see Box 3.1).

The previous Labour Protection Act required employers to protect the health of their employees in a comprehensive manner, but this only implicitly included mental health. Explicitly spelling out psychosocial risks is a promising development. Another is the recognition of occupational psychologists as practitioners who may be called upon to evaluate workplace risks and develop measures to address them. However, the reformed Labour Protection Act falls short of its aims. Occupational psychologists are not acknowledged fully as "preventive professionals". They can be mandated only for up to 25% of the total time that employers are obliged to engage occupational health and safety specialists every year. What is more, the 25% rule is voluntary and applies only to bigger enterprises (with more than 50 employees). There are still obstacles in the way of an increased involvement of psychologists.

The Austrian Workers' Compensation Board (AUVA) – providing social security for occupational health and safety risks – is the chief partner for small and medium-sized enterprises when it comes to work-related mental health problems. However, AUVA focuses almost wholly on accidents in the workplace – only around 1% of its spending is on work-related illness, which does not even include work-related psychological problems. Recently, however, AUVA has started to consider the issue of psychological stress at work.

In 2013, AUVA's prevention centres provided advice by safety consultants to around 54 000 firms and by occupational physicians to another 54 000. In most cases, occupational physicians assessed whether firms had undertaken psychosocial risk assessments; only one in three had (AUVAsicher, 2013). There is still a way to go before AUVA becomes a consultant in assessment and work-related mental health problems.

Since Austria joined the European Union in 1995, labour protection has become a fast-growing issue and occupational medicine is now a well-developed field. Employers are responsible for the protection, safety, and the general well-being of their employees. Every enterprise, irrespective of its size, has to seek support from occupational risk prevention services. Those with more than 50 employees widely use internal prevention specialists for a minimum number of hours every year (see Box 3.1). However, 98% of all Austrian firms payroll has less than 50 employees (Figure 3.4, Panel A).

Box 3.1. **The new Labour Protection Act obliges employers to evaluate psychological work strain**

Most reforms contained in the new Austrian Labour Protection Act, which became law in January 2013, are clarifications of existing requirements.

- Psychological strain is identified as a risk factor. (It may be related, for example, to the lack of support or feedback from supervisors, unclear or conflicting tasks, poor participation, or work with little variety).
- "Health" is defined as physical *and* mental health.
- Employers are required to conduct workplace evaluations i.e. systematically identify and document workplace risks, implement measures and evaluate their effectiveness.
- Workplace evaluation has to include a preventive focus, which entails evaluating tasks and how they are organised, the working environment and operational procedures.
- In the event of occupational incidents with a significant component of psychological strain, employers are compelled to conduct new workplace evaluations.
- Occupational psychologists (like chemists, toxicologists and ergonomists) are recognised as professionals adequate to the task of workplace health evaluation and may be mandated to that effect.

Employers are no longer obliged only to secure a healthy work environment but to actively evaluate psychological strain in the enterprise. They should conduct evaluations systematically through a steering committee that includes employee representatives and using standardised screening instruments or questionnaires. While employers are free to choosing evaluation methods, they have to be validated. Smaller enterprises may carry out evaluations through structured group interviews or interviews with individual employees.

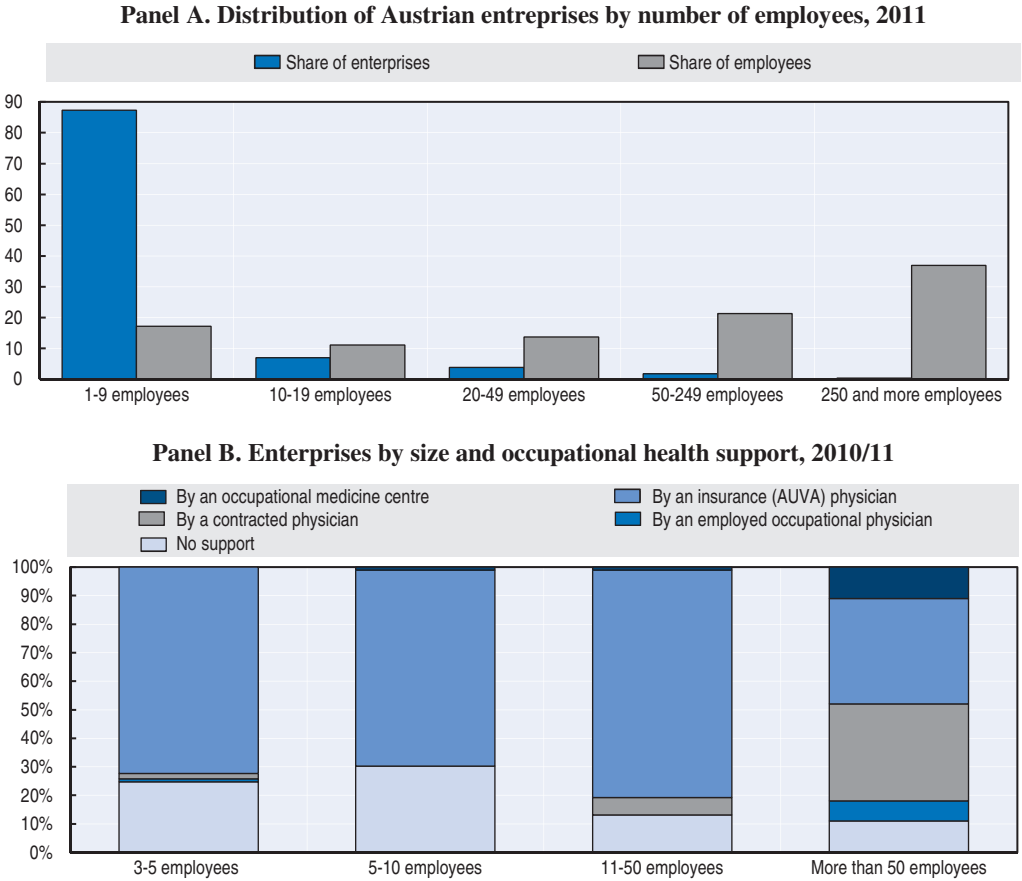
Prevention professionals

The new act compels all employers to ensure their employees' occupational safety and health through the use of qualified "prevention specialists", i.e. occupational safety practitioners or occupational physicians. There are several ways to deploy their services in the enterprise – be it by regularly employing a prevention specialist in-house, by contracting an outside consultant, or by co-operating with the Centre for Occupational Health and Safety.

Enterprises with more than 50 employees must employ occupational health and safety specialists for at least 1.2 hours of risk prevention per year for every workplace and full-time employee. For workplaces with manual work and night shifts, the rate is 1.5 hours. A workplace safety expert should take up at least 40% of that prevention time, an occupational physician at least 35%, and other professionals, like occupational psychologists, the remaining 25%. Smaller enterprises with less than 50 employees often use the services of accident insurance prevention centres, which are free of charge.

Firms with up to 10 employees should be visited by consultants at least once every two years, while those with 11-49 workers should be seen at least twice a year by both an occupational safety expert and an occupational physician together.

Figure 3.4. **The many small enterprises in Austria have limited support by occupational health specialists**



Source: Panel A: Statistics Austria and Panel B: Spectra (2011), "The position of occupational medicine in enterprises", A survey commissioned by the Austrian Academy for Occupational Medicine.

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Some 87% of all enterprises have less than 10 employees and only 2.1% more than 50. However, 58% of all employees work in the big companies and, therefore, mostly benefit from the service of internal occupational health and safety practitioners. In firms which employ ten or less people, an inspection by the labour inspectorate is carried out every other year. Altogether, AUVA assesses and advises roughly 70% of all Austrian enterprises, but most small companies have limited

access to support. Among businesses with less than ten employees, for example, 25-30% do not get any occupational health support at all (Figure 3.4, Panel B).

Still too much focus on safety and not enough on mental health

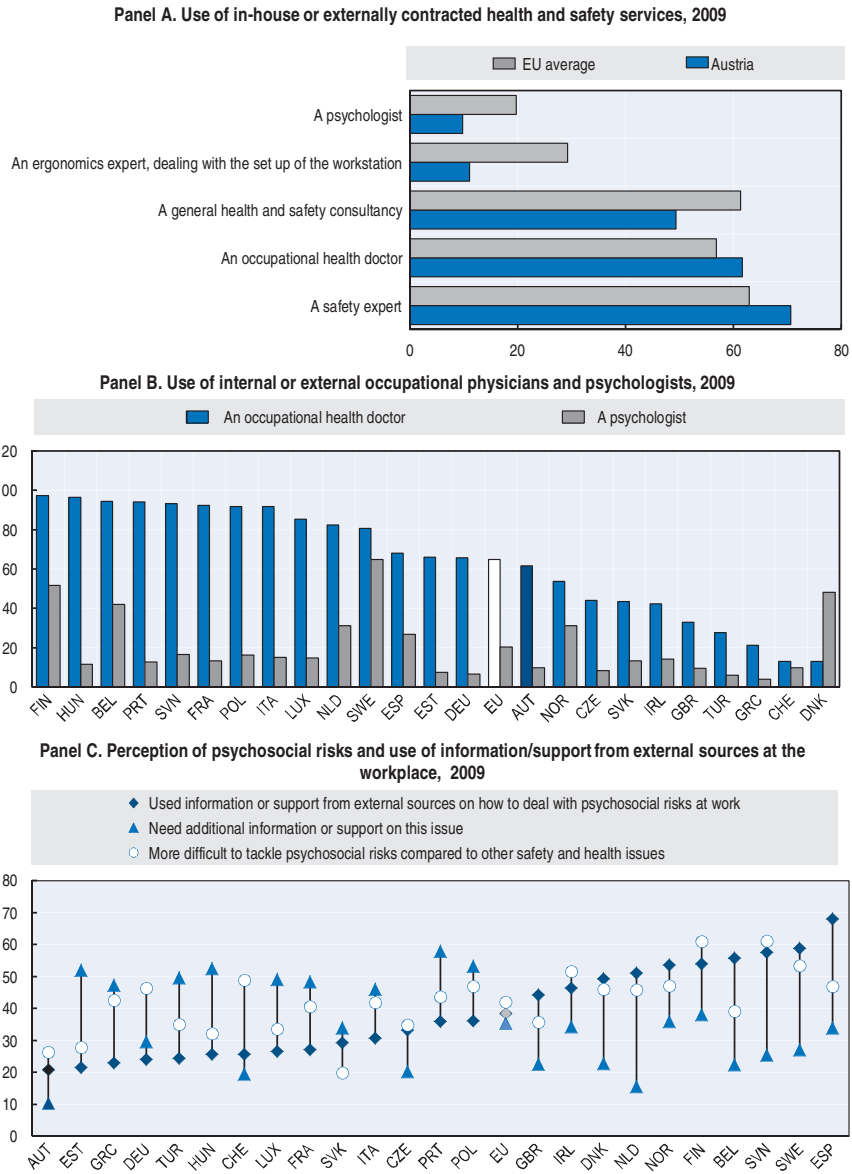
Austrian enterprises differ from those in many other countries in their practice of health and safety. Around 70% – significantly above the EU average – call on the services of safety consultants and make less use of other services (especially those of ergonomics specialists and psychologists) than in other countries (Figure 3.5, Panels A and B). Occupational health and safety in Austria still focuses heavily on safety – in other words, on preventing workplace accidents – at the cost of mental health and ergonomic issues like adapting the workplace to employees with a health problem, whether physical or mental.

Austria ranks lowest in the OECD when it comes to:

- the use of outside consultants to address psychosocial risks
- the perceived need for more information on psychosocial risks
- the perception that reducing psychosocial risks is more difficult than handling other risk factors in the workplace.

Only one in ten Austrian enterprises express a need for additional information about or support for psychosocial risks (Figure 3.5, Panel C). There is still some way to go change employers' mind-sets, as confirmed by the recent findings of a representative telephone survey of 300 enterprises commissioned by the Austrian Academy for Occupational Medicine (Spectra, 2011). A high proportion of small firms (30-50%) consider information on burnout or psychological strain as "not relevant" to them (Figure 3.6). With around one-fifth of the working population experiencing mental health problems every year, that attitude reveals a substantial lack of awareness. That being said, addressing mental health problems at work is difficult because they are intangible, seldom disclosed, often enduring, and affect the workplace atmosphere (OECD, 2012).

Figure 3.5. **Plenty of safety experts, few mental health professionals**

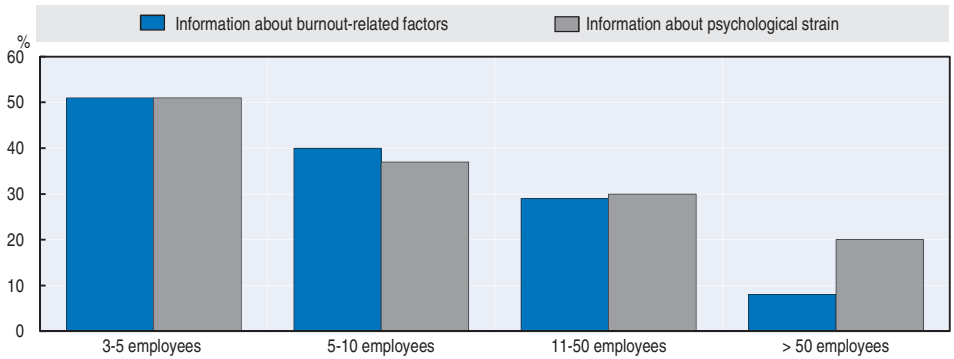


Source: OECD compilation based on the 2009 European Survey of Enterprises on New and Emerging Risks (ESENER) of the European Agency for Safety and Health at Work; https://osha.europa.eu/sub/esener/en.

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Figure 3.6. **Smaller firms do not want information on mental health problems**

Tasks of occupational medicine considered not relevant to the enterprise, by size of the enterprise



Source: OECD compilation based on data of: Spectra (2011), "The position of occupational medicine in enterprises", A survey commissioned by the Austrian Academy for Occupational Medicine.

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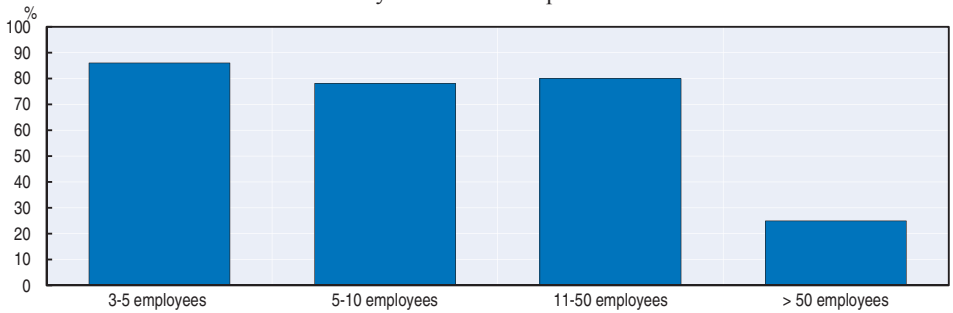
Small and medium-size enterprises lack support

Although SMEs appear to profoundly underestimate mental health-related work problems, the picture varies slightly with company size. Between 40% and 50% of firms with less than 10 employees think they can manage problems without occupational physicians, a share that drops to 10%-20% in bigger companies (Figure 3.7).

Nevertheless, SMEs do experience problems with employees who suffer from psychological disorders. There is evidence that they are partly attributable to inadequate support from the health and safety authorities, low acceptance of such support, or both. Occupational medicine in Austria often fails to fulfil firms' needs across a range of issues which they regard as important (Figure 3.8). While it does appear to meet most needs that relate to work organisation, task planning and physical strain, it falls short of answering mental health needs. Alcohol and substance abuse, for example, particularly affect small firms. Yet only some 25% of employers who see this as a serious problem report that occupational medicine gives them sufficient support (Figure 3.9).

Figure 3.7. **Smaller firms declare they can manage health problems on their own**

Share of employers who claim to manage without an occupational physician in their enterprise, by size of the enterprise

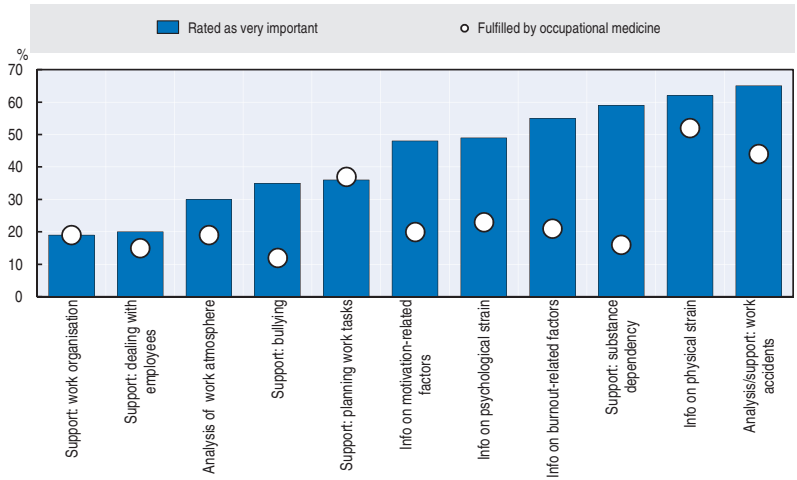


Source: OECD compilation based on data of: Spectra (2011), "The position of occupational medicine in enterprises", A survey commissioned by the Austrian Academy for Occupational Medicine.

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Figure 3.8. **Wide discrepancies between needs that firms rate as important and needs met by occupational medicine**

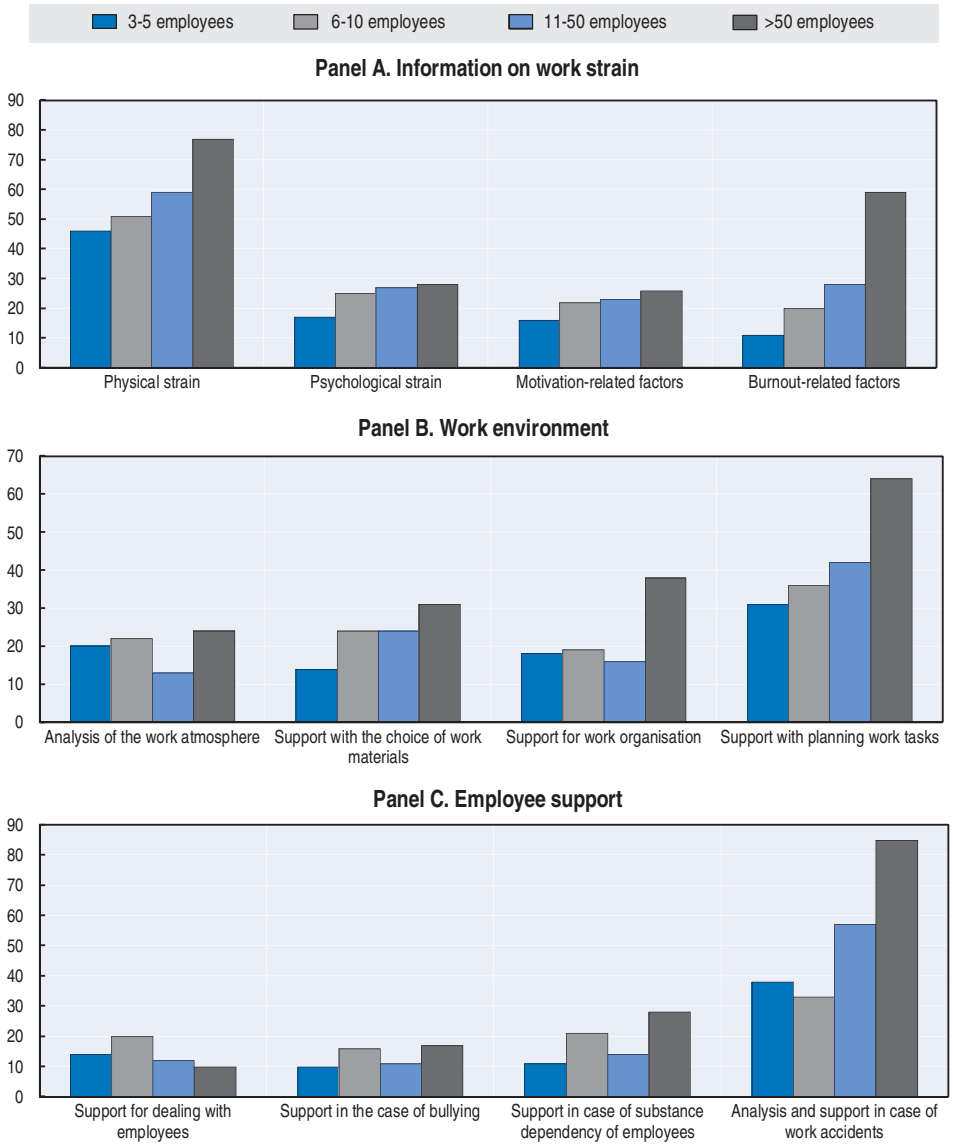
Important needs that enterprises believe occupational medicine should meet and the needs they consider it does meet



Source: OECD compilation based on data of: Spectra (2011), "The position of occupational medicine in enterprises", A survey commissioned by the Austrian Academy for Occupational Medicine.

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Figure 3.9. **The occupational health needs that are met, by firm size**



Source: OECD compilation based on data of: Spectra (2011), "The position of occupational medicine in enterprises", A survey commissioned by the Austrian Academy for Occupational Medicine.

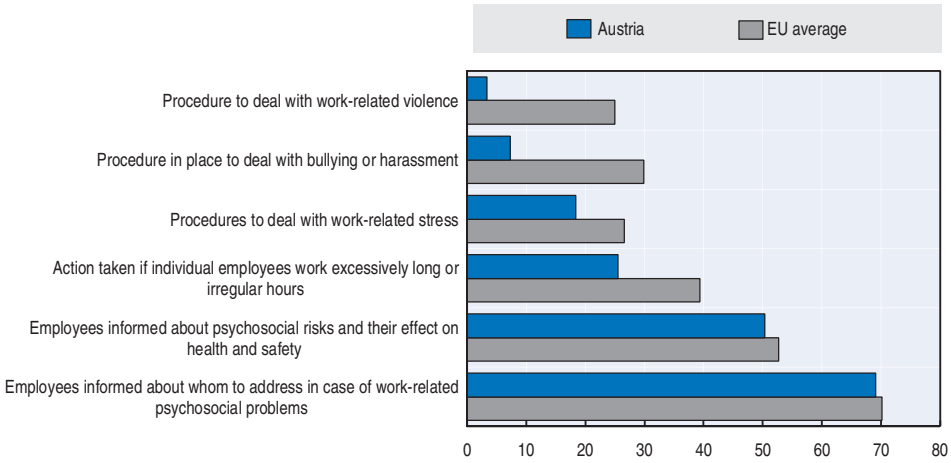
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Big companies are more aware of work-related mental conditions. Having in-house occupational physicians seems to change perceptions. While around 60% of enterprises who payroll more than 50 employees feel well informed about burnout-related factors, for example, only some 10% of very small firms do (Figure 3.9, Panel A). The percentage is the same when it comes to those who feel they receive enough support to cope with employees who have alcohol problems (Panel C).

There appears to be an imbalance in Austria's occupational health provision between general information and specific action. Austria informs and educates its enterprises and their employees as well as other European countries when it comes to psychosocial risks and whom to contact in the event of common workplace problems. By contrast, it lags behind its European peers in the provision of procedures for dealing with particularly fraught workplace situations, such as those that spring from work-related stress (Figure 3.10).

Figure 3.10. **Austria lacks management procedures for dealing with problematic psychosocial situations in the workplace**

Percentage of firms with the right information and/or procedures in place for dealing with workplace health issues



Source: European Survey of Enterprises on New and Emerging Risks (ESENER) of the European Agency for Safety and Health at Work; https://osha.europa.eu/sub/esener/en (accessed 1 June 2015).

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To sum up, there are several barriers to more effective occupational medicine in Austria and to enterprises' use of its full potential.

- Smaller companies are widely ignorant of the importance of psychosocial risks and mental health problems in the workplace and underestimate how difficult it is to deal with such problems without professional help.

- Occupational health services are not sufficiently present in smaller enterprises – primarily because employers take a dim view of the usefulness of occupational medicine, which perpetuates a vicious circle.

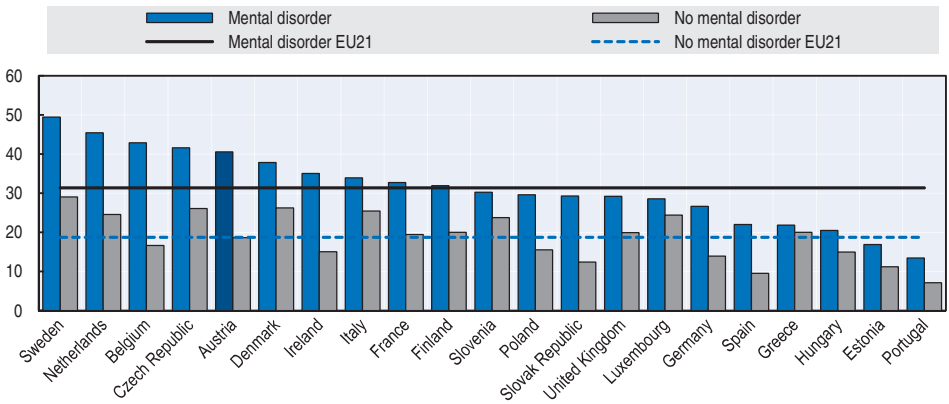
- Occupational health and safety still focuses heavily on general accident prevention and physical illness. The nascent new focus on psychosocial risks has yet to be fully developed. The support currently provided puts the onus on information and evaluation, but offers little help on early intervention or the development of procedures for tackling problematic situations.

The "wait-and-see" culture in sickness absence must be overcome

Prolonged sickness absence is the main path into the disability benefit system (see Chapter 2). Preventing and actively managing sickness absence among workers with a mental illness is crucial to containing the growing number of mentally ill claimants on disability benefit. At 20% of the workforce, the incidence of sick leave among employees with no mental disorder in Austria is close to the average rate observed among 21 EU countries. As for employees with mental disorders, however, the Austrian sickness absence rate is far above the average of around 30% (Figure 3.11). Austria ranks a close fifth to countries like Sweden and the Netherlands which (back in 2010) were known for their generally higher sickness absence rates.

Figure 3.11. **While levels of general sick leave in Austria are average, they are very high among employees with mental disorders**

Incidence of sickness absence (number of absences in the previous four weeks), by mental health status and country, 2010



Note: The EU21 is an unweighted average of the 21 European countries in the chart.

Source: OECD calculations based on Eurobarometer 2010.

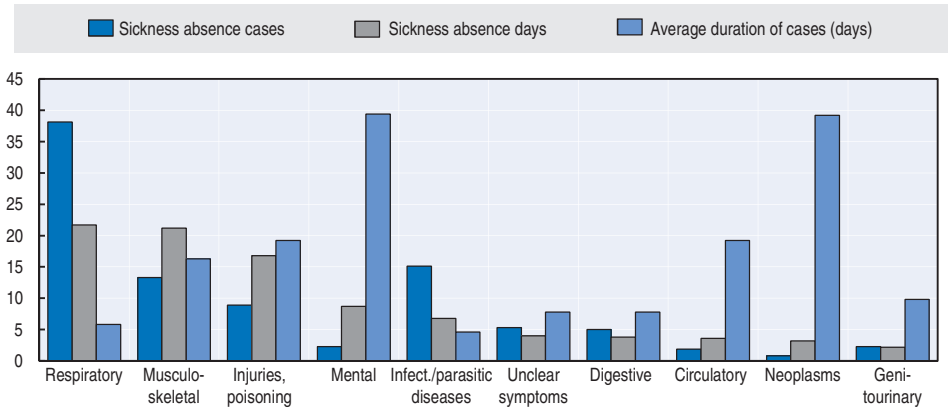
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Sick leave for reasons of mental ill-health is under-reported

Although population survey data show high absence rates among workers with mental disorders, official Austrian sickness statistics suggest that relatively few sickness absences are actually caused by mental ill-health – only 2.3% in 2013 (Leoni, 2014b). The figure is small compared to physical complaints, for example, which accounted for 13.5% of all instances of sick leave (Figure 3.12). However, because sickness absences due to mental health problems are so long, mental illness accounts for 8.7% of all days off for sickness and ranks in the top four reasons for sick leave. Mental disorder is the only sickness absence diagnosis to have shown a real increase in Austria over the past two decades; starting from an extremely low number, sick leave days have risen 300% since 1994. But even today, the reported level of sickness leave for reasons of mental ill-health hardly reflects the true picture (Leoni, 2014a).

Figure 3.12. **The ten leading causes of sickness absences in Austria**

Share of cases and days of sickness absence as percentages of all cases/days, and the average duration of absence per case, by medical condition, 2013



Source: OECD compilation based on data of the Association of the Austrian Social Insurances (*Hauptverband der österreichischen Sozialversicherungsträger*), in Leoni, T. (2012), *Fehlzeitenreport 2012 – Krankheits- und unfallbedingte Fehlzeiten in Österreich* [Sick leave report 2012 – Absences due to health conditions and accidents in Austria], Österreichisches Institut für Wirtschaftsforschung.

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Compared to countries like Sweden and Norway where mental illness accounts for 15%-20% of all instances of sick leave (OECD, 2013b; OECD, 2013c), the low figure in Austria hints at specific issues. Awareness of mental health problems seems to lag behind other countries and fears of disclosing a mental health problem seem to be much greater. The high incidence of comorbid physical disorders affords physicians opportunities to diagnose physical rather than psychiatric complaints. Although doctors might be acting in the belief that they are shielding patients from stigma, they may also be obstructing the return-to-work process. Without a true analysis of the health-related work problem, it is not possible to develop effective rehabilitation measures. A more reliable diagnosis is not made until a worker claims a disability benefit.

Mental disorders are highly disabling conditions, as is borne out by the length of sickness absences they cause – more than 35 days on average (Figure 3.12). That figure is more than seven times longer than absences due to intestinal infections or respiratory diseases. Most employees with physical complaints are back to work within a few

days, which seldom impacts job retention. Being away for five weeks, though, and much longer in many cases, is likely to have an adverse effect on the employee's work and likelihood of keeping his/her job.

Sick leave regulations are the main barrier to job retention

It is not common practice in Austrian firms to monitor and follow up on employees on sick leave (Figure 3.13). Austria lies at the very low end of the European spectrum for the share of firms that routinely analyse the causes of sickness absences. Scarcely 25% of firms do so – half the European average of around 50%. The failure to look into the circumstances behind sickness absences is a great opportunity missed for learning how to identify problems and intervene early.

Similarly, few firms in Austria – especially small ones with less than 50 employees – take measures to follow up on employees on long-term sick leave in order to support their return to work. Austria ranks second lowest in Europe for the share of companies that follow up on employees on long-term sick leave. Its rate is under 30%, far short of the 60% European average and a particular failing when it comes to sickness absences for mental illness as they are generally lengthy.

The wait-and-see culture in Austrian enterprises has to be seen against the legal background regarding sick leave. There are a number of regulations that hinder early employer action – in sharp contrast to evolving sickness management practices in many OECD countries (Box 3.2). The main barriers are:

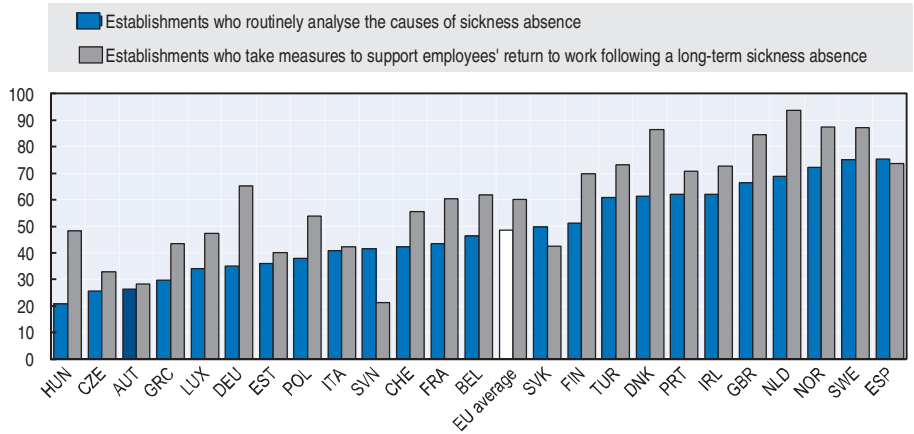
- Employers are not entitled to ask the reason for a sickness absence. They are informed only whether absence is due to sickness, a workplace accident, or another accident.
- An employer is not allowed to know the prognosis for when an employee is expected to return to work.
- The Austrian system does not provide for partial capacity to work – in other words, employees may only be on full sick leave or working full-time in their usual job. Such inflexibility hinders the gradual resumption of work after long-term sick leave and runs counter to the evidence that gradual returns to work can be an important factor in recovery from many mental health conditions, e.g. depressive disorders.
- Employers may not ask for back-to-work meetings (*Rückkehrgespräch*) during employees' sick leaves. They may do

so only after employees resume work – for example, in order to ask how the workplace may be adapted to their needs.

- Employment protection legislation implicitly empowers employers to dismiss employees on sick leave without giving a reason.
- Employers' financial obligations to employees on sick leave are limited. They usually have to pay full wages for the first six weeks of sick leave (up to 8/10/12 weeks for 5/15/25 years of tenure).

Figure 3.13. **Austrian businesses rarely monitor sickness absences**

Share of enterprises that monitor and follow up employees on sick leave, 2010



Source: European Survey of Enterprises on New and Emerging Risks (ESENER) of the European Agency for Safety and Health at Work; https://osha.europa.eu/sub/esener/en (accessed 1 June 2015).

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To summarise, employers have almost no rights in the event of long-term sick leave and limited financial incentives to invest in back-to-work measures. Yet they are allowed to dismiss absent employees. Clearly, regulations do not create a setting conducive to mentally unwell employees who are absent on sick leave:

- They may exhibit problematic behaviour in the workplace that can be managed only if it is understood. Yet employers are not allowed to ask for information on their condition when they are absent.
- When they are absent they are difficult to appraise, yet employers cannot enquire into the prognosis.

- They could to do some work while sick. Yet partial sick leave is not possible.
- If they are often on long-term sick leave, their chances of being dismissed are greater.

Box 3.2. **Sickness absence management: Examples from other countries**

A number of countries have developed detailed procedures for shortening sickness absences and improving the return-to-work rate among people on long-term sick leave, including Denmark, the Netherlands, Norway, Sweden and Switzerland.

Early contacts between employers and sick-listed employees

In Norway, Sweden, the Netherlands and Denmark, employers are required to contact employees on sick leave swiftly (within around one month) in order to discuss their ability to work, in what conditions they may resume work and to draw up follow-up plans. This first step is followed by a series of further actions, usually with the participation of a social security case manager and, if possible, the treating physician. All four countries have implemented reforms and introduced procedures in order to involve employers much earlier in the return-to-work process and get them to build a relationship and meet with sick-listed employees. As research shows, regular contact between employers and sick employees is an important factor in successful returns to work (Cornelius et al., 2011; Nieuwenhuijsen et al., 2004).

Regulations to strengthen sickness monitoring are especially effective when they offer employers strong financial incentives to comply. The Netherlands, for example, has transferred the financial liability for sickness benefit from social security to employers who have to assume the cost of sickness benefit for up to two years. During that period, employees cannot be dismissed as long as they comply with their obligations.

Education and guidelines for physicians

Education and guidelines for physicians on effective, differentiated sickness certification practice are important. Physicians find prescribing sick leave for mentally unwell patients problematic. They feel awkward about assessing the right length and nature of sickness absences or establishing long-term prognoses of fitness to work (Winde et al., 2012). Moreover, it is common for them to draw up sick-leave certificates that meet patients' expectations so as not to endanger the patient-doctor relationship (Norrmén et al., 2008). Norway has undertaken several initiatives to build awareness that partial sick-leave can support recovery and job retention among people with mental disorders (Kann et al., 2012). Sweden has developed sickness certification guidelines primarily to support GPs. Today, three in four

Swedish GPs use these guidelines which were developed with the support of the medical association (Skaner et al., 2011). In the United Kingdom, GPs have to fill out so-called "fit notes" in lieu of "sick notes" since 2010. In fit notes, physicians indicate whether patients are fit or not to work under certain specified conditions (e.g. workplace adjustments, gradual returns to work).

Box 3.2. **Sickness absence management: Examples from other countries** *(cont.)*

Case management during sickness absence

In Switzerland, there are no such mandatory procedures, but almost all private daily allowance insurers have built up case-management units. Depending on the specifics of the contract between the insurer (who pays the wages of employees on sick-leave) and the employer, specialised case managers contact the treating physician and the sick employee within the first weeks or months of absence in order to evaluate and monitor the situation and agree on a back-to-work plan. The main challenge is to establish a good relationship between the employee, the employer, the treating physician and the case manager in order to agree on a shared definition of the work problem and any necessary support.

The United Kingdom plans to go even further with its national "Health and Work Service". The service may be accessed directly by the sick-listed employee or through referral by a GP or an employer. The service will provide – with the involvement of the sick employee, the employer and the treating GP – an in-depth assessment of the employee and their work problem, a return-to-work plan and support for employers and employees. The scheme appears to have fine potential in that it integrates health and work issues.

Source: Cornelius, L. et al. (2011), "Prognostic Factors of Long Term Disability Due to Mental Disorders: A Systematic Review", *Journal of Occupational Rehabilitation*, No. 21, pp. 259-274.

Nieuwenhuijsen, K. et al. (2004), "Supervisory Behaviour as a Predictor of Return to Work in Employees Absent from Work Due to Mental Health Problems", *Occupational and Environmental Medicine*, No. 61, pp. 17-23.

Winde, L. et al. (2012), "General Practitioners' Experiences with Sickness Certification: A Comparison of Survey Data from Sweden and Norway", *BMC Family Practice*, Vol. 13, No. 10 www.biomedcentral.com/1471-2296/13/10 (accessed 1 June 2015).

Norrmén, G., K. Svärdsudd and D. Andersson (2008), "How Primary Health Care Physicians Make Sick Listing Decisions: The Impact of Medical Factors and Functioning", *BMC Family Practice*, Vol. 9, No. 3.

Kann, I. et al. (2012), "Har gradert sykmelding effekt pa sykefravaeret?" [Can partial sick leave stem absenteeism?], *Arbeid og velferd*, No. 2, pp. 60-70.

Skaner, Y. et al. (2011), "Use and Usefulness of Guidelines for Sickness Certification: Results from a National Survey of All General Practitioners in Sweden", *BMJ Open*, No. 1, e000303, http://bmjopen.bmj.com/content/1/2/e000303.full (accessed 1 June 2015).

The social partners should agree on sick-leave regulations

Austrian employer organisations have repeatedly called for more flexible medical assessments of fitness to work to allow partial work capacity and facilitate a gradual return to work. The trade unions, however, have so far blocked such moves. Only as regards the workplace re-integration of employees on long-term sick leave does there seem a willingness to accept reduced working hours. Such an unbending stance narrows the options for intervention.

Yet other countries – such as Sweden (OECD, 2013b) and Norway (OECD, 2013c) – have issued guidelines for physicians that encourage them to advise partial work incapacity ("graded sick leave") whenever possible. In Norway, the rate of graded sick leave in mental disorders is around 25%. It generally applies to shorter sickness absences, so whether it may work with sick-listed workers who have a mental health condition is an open question (Hogelund and Holm, 2011).

In many OECD countries, sickness absence certification can be graded. A case in point is Switzerland, where recent developments could be relevant to Austria. In some Swiss regions, employers' and doctors' organisations have jointly developed detailed sickness absence certification. In the event of lengthy sick leave an employer can request a detailed certificate (together with costs) from the treating physician. It describes what tasks a patient can and cannot perform in their particular condition. The GP responds with an indication as to when he or she will be able to supply a more precise response. So that the doctor can form an opinion, the employer forwards – with the employee's consent – a short description of the workplace and the sick employee's tasks. Although employers may also state whether they wish to deal personally with the treating physician, there is no exchange of information over diagnosis or other medical issues. While the Swiss certification practice has not been evaluated so far, there is anecdotal evidence that it has improved communication between employers and GPs.

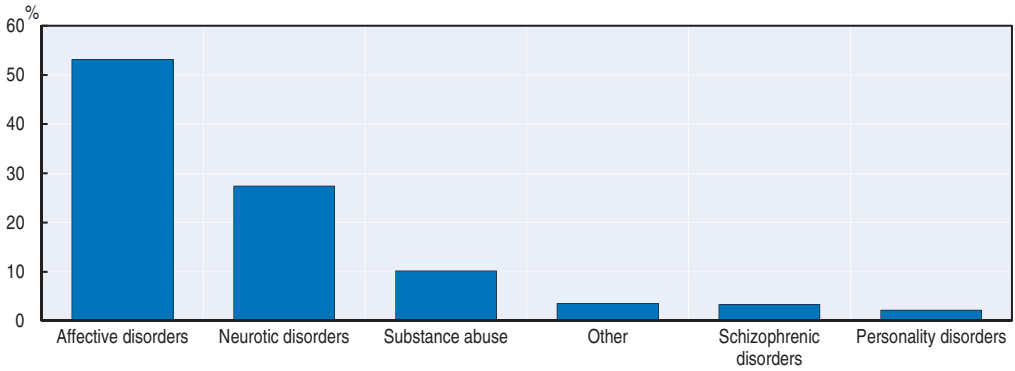
When it comes to the diagnosed causes of sick leave for mental health reasons in Austria, affective and neurotic disorders are the most frequent (Figure 3.14). They account for almost 80% of all mental health-related sick leaves. While depressive disorders are known for their adverse effects on the ability to work, it is also well known that sick-listed employees with depression benefit from getting back to work early (OECD, 2012) and having supportive employers who keep in touch (Brouwers et al., 2009; Muijzer et al., 2011; Plaisier et al., 2007). When sick employees settle in to their role as a sick person rather than as an employee and focus on their symptoms instead of seeking to resume work – even part-time – they reduce their chances of actually returning to their job (Millward et al., 2005). Because the average duration of sick leave for depression or a neurotic disorder in Austria is much longer than for physical complaints (45 days for depression and 35 for neuroses in contrast to 10 days for physical illness), more active support is crucial.

Moreover, in many depressive complaints and most neurotic disorders, e.g. anxiety or physically inexplicable pain, fear avoidance

plays a role (Oyeflaten et al., 2008; van Rhenen et al., 2008). It is known that fear-avoidance behaviour grows more acute with time, which is why active interventions to support early returns to work are so important. It is critical that much higher numbers than the currently low share of Austrian firms should engage in such interventions in the future.

Figure 3.14. **Affective disorders account for half of all sickness cases with a mental health condition**

Proportion of specific disorders in all mental disorders causing a sick leave, 2009



Source: *Hauptverband der österreichischen Sozialversicherungsträger* and GKK Salzburg (2011), *Analyse der Versorgung psychisch Erkrankter - Abschlussbericht*.

StatLink http://dx.doi.org/10.1787/888933239253

The new fit2work service has expanded substantially

The Austrian government has acknowledged the urgent need for return-to-work support for workers on long-term sick leave. Together with the social partners and the social security authorities, it has initiated a new low-threshold service for occupational information, counselling and support. Known as "fit2work", its purpose is to prevent job loss and long-term unemployment. It caters not only to sick-listed employees and unemployed persons, especially those with a mental illness, but to enterprises, too.

Fit2work counsellors are professionals in such fields as occupational medicine, occupational psychology and social work. Private counselling firms provide the support and, though they cannot provide any psychotherapy themselves, they can enable prompt access to therapists in the event of mental health problems. *Fit2work* chooses

these counselling firms for the quality and costs of the services they offer and requires them to be qualified and have practical experience.

Fit2work started in 2011 in a handful of regions and by 2013 had gone nationwide with some 40 sites. Early evaluation in three trial regions over the period 2011-13 showed that the use of the new service was initially lower than expected: around 4 000 people accessed *fit2work's* information services rather than the 6 600 expected, and only 900 received case-managed counselling – in contrast to the projected 3 300 (Egger-Subotitsch and Stark, 2013). Uptake was generally low: only about 10% of all people who had been on sick leave longer than 40 days and had been contacted by the medical insurance services.

However, more recent data show that *fit2work* has rapidly expanded in recent years. To date, some 40 000 people have received information, 24 000 counselling and 12 000 case-managed support. Accordingly, total spending for *fit2work* services rose from around EUR 500 000 in 2011 to around EUR 9 million in 2014, and is projected to increase to EUR 15 million in 2015.

Fit2work is accessed chiefly through GPs, the PES, or self-referrals. The bulk of users – 42% – suffer from mental disorders, while 37% have a physical health complaint. Many are not on sick leave at the time of service use, but unemployed – 56% in 2013 (fit2work, 2014).

In principle, fit2work seems to match the needs of employees and the unemployed with mental health conditions. Yet, despite its promising performance in helping growing numbers of the mentally unwell to keep their jobs or return to work early, it is critical that it addresses, or continues to address, a number of aspects of the service it provides.

Fit2work services can be more effective

Late referrals and weak ties with the mental health care system

Fit2work's services cannot be fully effective if not integrated with mental health treatment and if clients are referred too late in the day.

The health authorities do not actively contact people on sick leave for the first 40 days of absence. For many of those suffering from mental health problems, such a long spell away from work without any support is detrimental. Many of fit2work's clients are such people and there is little fit2work can do for them when they are referred too late.

Fit2work needs to communicate and interact more closely with the mental health care system and integrate its services with the treatment provided by GPs, psychotherapists and psychiatrists. It could then intervene much earlier and its services would produce their full effect.

Shortages of places for treatment and rehabilitation persist

The service *fit2work* most frequently provides is general information. Demand for direct and workplace-focused counselling is likely to grow, however. One of the early *fit2work* assessments in 2011-13 stated that the counselling service had helped younger people more than older workers; only 20% of all employees over 45 could improve their ability to work (Egger-Subotitsch and Stark, 2013). This is a critical finding when seen against the high proportion of Austrian employees who leave the labour market many years before the official retirement age.

A good many employees were found to be in need of psychotherapeutic treatment which is often not available at short notice (fit2work, 2013). To fill that gap, *fit2work* and the Association of Austrian Psychologists came up with a promising initiative in 2013 for providing additional psychotherapy places at short notice. There are currently around 1 300 places available for psychological and psychotherapeutic treatment of fit2work clients. After 30 hours of therapy, medical insurance takes over funding – and the patient continues with the same therapist.

A recent *fit2work* evaluation points to positive outcomes. Roughly 40% of the initially unemployed clients were fit to go back into the labour market. Counselling, rehabilitation and psychotherapy also improved mental health conditions and health behaviour, and reduced the use of health care services (Jagsch, 2015).

Waiting times for places in mental rehabilitation facilities, however, generally continue to be long. The result is unnecessarily long periods of inactivity. Employees on lengthy sick leave for reasons of mental health are reluctant to go back to work before rehabilitation, and employers baulk at hiring workers who are likely to be absent for some time (fit2work, 2014).

Employers need pragmatic advice on mental ill-health

Employers are fit2work's second main target group, and it is only now reaching them to any significant degree. Since *fit2work* came into being in 2011, it has counselled around 650 employers. Of those, it

offered 410 firms step-one support, which comprises advice and information and basic assessments of their needs. To the other 240 it provided step-two services, conducting comprehensive workplace analyses and putting in place sustainable support structures within the enterprise.

Fit2work does not yet offer sufficient concrete counselling on what to do in situations where an employee exhibits problems related to mental health in the workplace. Such support would be especially valuable to smaller firms, though.

Despite its recent success in reaching out to enterprises, fit2work does not yet serve many of them. If it is to become a more widely-used mainstream service for employers, it has to make the business case for intervening in health-related work problems more clearly. It should put greater focus on the kind of support that enterprises – particularly small and medium-sized ones – request. And it should continue its efforts to raise public awareness of the benefits of early intervention to help workers with mental health problems.

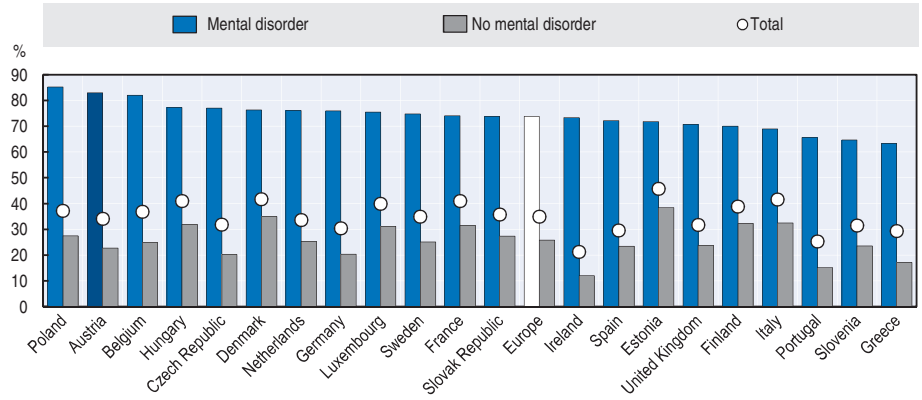
Mental health-related presenteeism should be a policy issue

Fit2work services target people who are on long-term sick leave for reasons of mental ill health. What occurs much more often, however, is so-called "presenteeism" of mentally unwell employees – they are present in the workplace but do not work productively because of health reasons, or not as productively as they normally do (Figure 3.15).

While the share of Austrian workers who have no mental health problem and do not work productively is similar to the 25% average in all European countries, presenteeism among mentally ill employees in Austria ranks second highest in Europe. More than four in five such workers report productivity losses at work. They are a group that has not received the policy attention it deserves.

Figure 3.15. **Presenteeism is high in Austria among workers with a mental health problem**

Workers who have not taken sick leave but whose productivity was low because of a health problem in the previous four weeks, by mental health status, 2010



Source: OECD calculations based on Eurobarometer, 2010.

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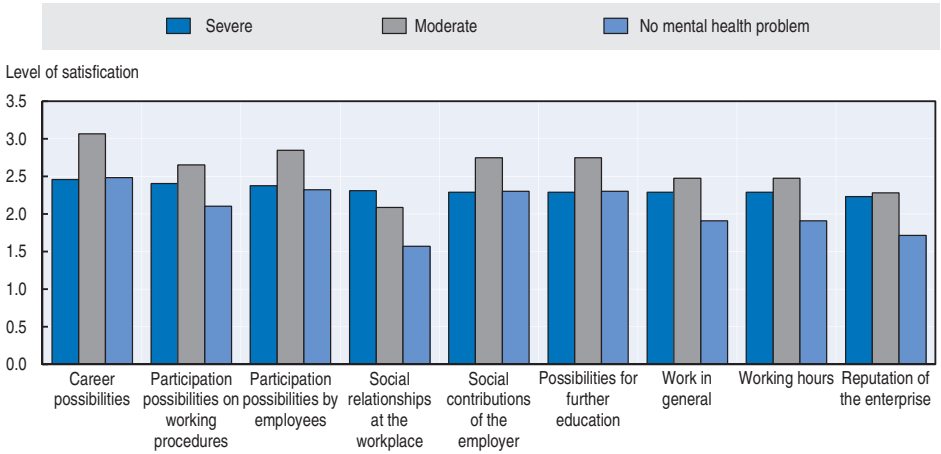
Employees with moderate mental health problems are a high-risk group

Austrian data suggest that the large group of workers who suffer, not from a serious mental health disorder, but from moderate ill-health may be a particularly high-risk group. Employees who are severely mentally ill and those who are healthy both report relatively high work satisfaction. But their peers with mild mental health complaints are the least satisfied (Figure 3.16, Panel A).

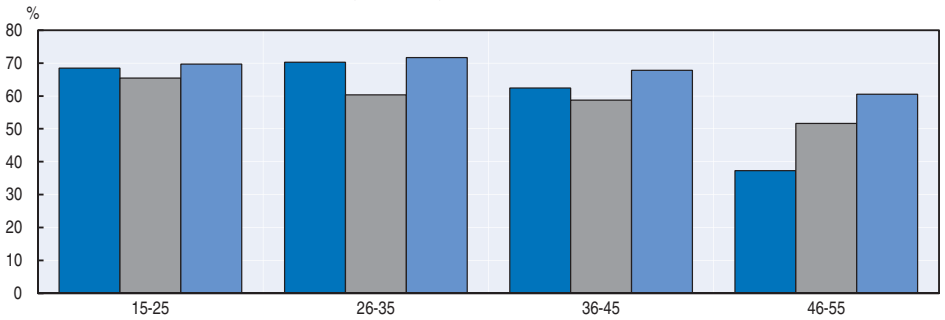
Austrian employees generally describe their career prospects and their possibilities to participate in the decision process as low. Policies to reduce presenteeism, sick leave and early retirement should address workers' gloomy outlook. Seemingly, they wish to perform well, succeed and participate, but feel all too often frustrated. It might be useful to evaluate whether a less hierarchical system with more flexible and personalised career planning would lessen the share of employees seeking to stop work before the legal retirement age.

Figure 3.16. **Employees with moderate mental ill-health are prone to low work satisfaction and a negative view of work**

Panel A. Level of satisfaction with different aspects of work, by severity of mental disorder, 2012



Panel B. Probability of working to the age of 65, by severity of mental disorder, 2011-13



Panel C. Reasons why still working at 65 is unlikely, by severity of mental disorder, 2011-13

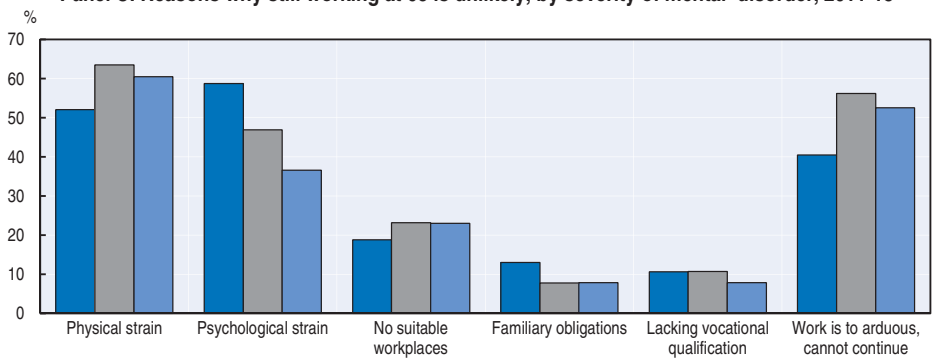
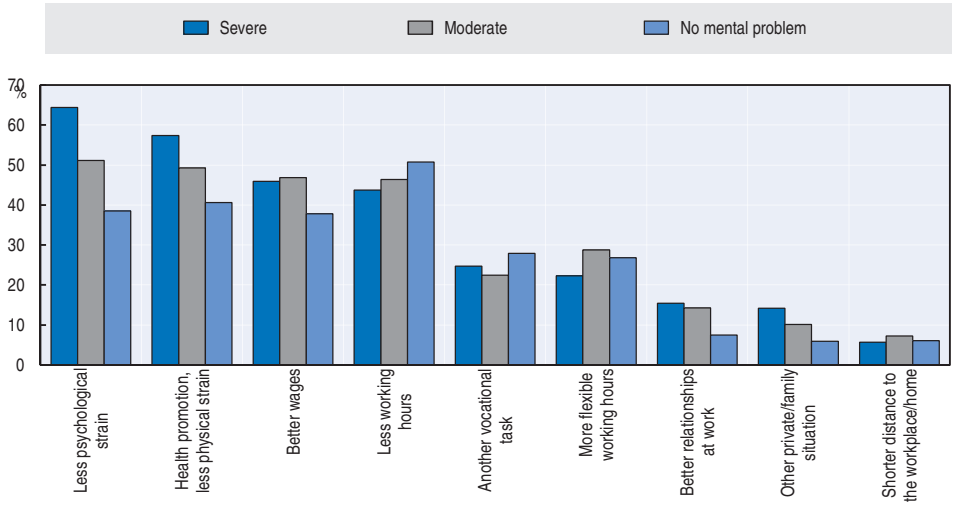


Figure 3.16. **Employees with moderate mental ill-health are prone to low work satisfaction and a negative view of work** *(cont.)*

Panel D. Aspects which would encourage persons to stay in work until 60 or 65, by severity of mental disorder, 2011



Note: Panel A – Level of satisfaction 1 to 5 (1=very satisfied, 5=not satisfied at all).

Source: OECD calculations based on data provided by the Upper Austrian Chamber of Workers.

StatLink http://dx.doi.org/10.1787/888933239272

The early retirement outlook is related to poor mental health

Many Austrian workers leave the labour market before the official retirement age. During their working life, those with mild-to-moderate mental health problems are especially negative about working until the age of 60/65 (Figure 3.15, Panel B). Generally, the number of workers who see themselves working through to retirement drops sharply after the age of 45, both among those with mental health conditions and those who face no mental health problems. Even among the latter, only around 60% of the 45-54 year-old age group picture themselves working until normal retirement.

The reasons for such a bleak perception of work (Panel C) and the possible solutions (Panel D) differ according to workers' mental health. Healthy employees regard physical strain as a problem and generally find work too demanding. Most feel that the solution would be to work fewer hours.

Employees with serious mental health issues suffer from psychological strain and would benefit from less stress. Those whose psychological problems are mild to moderate actually take much the same view as their healthy peers. They suffer from physical strain, perceive their job as too demanding, and would like to work more flexible, shorter hours. Taken together, the data suggest that the early retirement outlook is not primarily the result of poor physical or mental health, but a cultural phenomenon – in other words, a negative view of work.

Round-up and recommendations

The workplace is a crucial area in which to intervene to tackle growing sickness absence and disability claims related to mental ill-health. In recent years, Austria has made significant strides: it has increased public awareness and broadened the scope of the Labour Protection Act. It has also strengthened occupational medicine, encouraged the use of occupational psychologists, and introduced a new fit2work service to support workers on sick leave and the unemployed affected by poor mental health.

The progress achieved has come through close collaboration between the social partners, social insurance services and the public authorities. What motivates and brings them together seems to be the aim of improving working conditions and minimising the physical or mental health damage caused by work. The prevailing focus on reducing psychological work stress is indeed important. However, it fails to address the increasing exclusion of mentally unwell employees from the labour market. The share of mentally ill people on sick leave or claiming disability benefit has steadily risen in the past two decades to very high levels. In this regard, legislation appears rigid and ineffective, and the social partners have not yet managed to agree on effective ways to monitor sickness absence and help people back to work. There is a wait-and-see culture in Austrian enterprises and no contact between employers, employees, case managers and treating doctors.

Productivity losses among mentally-ill employees are also high. The resulting high social and economic burden, together with the very low effective retirement age, points to the large number of employees with mild-to-moderate mental health problems as a critical concern. They are particularly dissatisfied with work and yearn for early retirement. There needs to be a greater effort to reach out to them.

Support employers in dealing with mentally-ill workers

- *Widen the current focus on workplace-based health promotion to pragmatic employer support.* Current policy promotes occupational health and seeks to prevent stress in the workplace. It must broaden its scope to early intervention in support of employees with work-related mental health problems. Mental health disorders start early and are never caused solely by adverse working conditions. Awareness-raising among employers should not be restricted to psychosocial risks at work. It should include pragmatic information on, for example, how to manage people who suffer from mental ill-health even before they join the firm.

- *Put psychological work stress into perspective.* Public discussion of psychological workplace stress has raised awareness of work-related mental health problems. Yet the one-sidedness of the debate disregards evidence and gets in the way of helping employees who were already suffering from poor mental health when they began work and who struggle to be productive. Public information campaigns need to be balanced by emphasising how important it is that employers should actively address problematic performance and behaviour in their employees.

- *Develop evidence-based and differentiated support procedures for employers.* The law requires that employers should know and understand mental health risks in the workplace. That requirement should be complemented by occupational health professionals developing interventions that work in different situations that stem from mental health difficulties in the workplace. Interventions may differ according to the type of the problem and the size of the enterprise.

- *Broaden the role of occupational health specialists.* The government should modify the labour protection law to i) provide more occupational health and safety prevention time in office-based work settings; and ii) strengthen the involvement of occupational physicians and psychologists. The Austrian Workers' Compensation Board (AUVA), which has an overarching role in occupational health and safety, traditionally focuses on workplace accidents. There should be closer collaboration between AUVA and mental health professionals, together with measures to better meet the mental health support needs of smaller enterprises.

- *Strengthen the employer focus of fit2work services.* In many mental-health problems in the workplace, it is just as important to provide support to managers and co-workers as it is to help a sick employee. There is a need for effective strategies to support supervisors and co-workers, and fit2work professionals should be trained accordingly.

Actively address sickness absences

- *Develop regulations and support for employers.* Obligations to monitor and intervene in sickness absences should be introduced and enforced. Employers would benefit from guidelines on how to address recurrent and long-term sick leave, how best to reach out to sick employees, and how to plan returns to work. It should be made clear what room for manoeuvre labour law gives employers in order to promote early interaction of employers with sick-listed employees and treating physicians.

- *Use partial sick leave more widely.* Sickness absence provisions should be more flexible to allow partial sick leave and gradual returns to work. To that end it is important to raise awareness of how partial sick leave can help to shorten absence due to poor mental health and improve returns to work. Guidelines to help GPs write precise, informative sickness certificates should be drawn up and they should be trained accordingly. To encourage GPs to comply with such guidelines, their sickness certification practices should be monitored and sanctions considered in the event of systematic non-compliance.

- *Oblige the health insurance services to intervene in the event of very long sick leave.* When sick leave becomes long and drawn-out, the health insurance services should not only advise the sick employee to contact fit2work, they should also appoint a case manager to support and follow up the employee.

Transform fit2work into a large-scale, integrated service

- *Make fit2work a large-scale service, but adjust target groups and interventions.* If fit2work is to expand its reach and provision, it needs to tighten up its services by shortening client waiting periods, better promoting services, focusing on job retention and short-term sick leave, and increasing concrete case management support. Currently, more than half of fit2work's clients are jobless. And, while it is important to support them,

fit2work should do more to address the needs of people who are still employed.

- *Further improve fit2work's co-operation with mental health care professionals.* Fit2work teams should routinely work not just with the PES, but also with health professionals. They should plan return-to-work procedures together with treating physicians and psychologists and work as a matter of course with psychiatric rehabilitation services. Finally, fit2work should seek to extend the prompt provision of treatment and rehabilitation when mental health disorders threaten jobs.

- *Better address mental health-related presenteeism.* A very high share of Austrian workers with mental health problems report reduced productivity. The expectation of premature retirement is highly prevalent among older workers, particularly when it comes to those with mild-to-moderate mental health complaints. There is a large group of employees with non-addressed mental health problems, who feel frustrated in their jobs and harbour hopes of early retirement. The sentiment is widespread and deserves to be explored. One avenue to go down would be to give older workers the chance to enhance their career prospects and offer them better financial incentives to work until the official retirement age.

Notes

1. The Work Climate Index is linked to the Austrian Occupational Health Monitor and measures the satisfaction of the Austrian population with different life domains, with a focus on job satisfaction and working conditions.

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Chapter 4

Improving the job prospects of vulnerable young people in the Austrian education system

This chapter assesses the capacity of the Austrian education system to support vulnerable children and young people with mental health disorders both in school and in the transition to the labour market. It focuses particularly on the availability of support measures for schoolchildren who suffer from mental ill-health and for their teachers and parents. It also considers to what extent the support provision has been professionalised and examines in detail recent coaching efforts to help students and apprentices stay in education or training. The success of the different support arrangements is critical in view of the relatively young age at which many young Austrians leave education.

The statistical data for Israel are supplied by and under the responsibility of the relevant Israeli authorities. The use of such data by the OECD is without prejudice to the status of the Golan Heights, East Jerusalem and Israeli settlements in the West Bank under the terms of international law.

Mental disorders begin early in life. The median onset age is 14 years and even as low as age 11 in anxiety disorders, for example (Kessler et al., 2005). Childhood and adolescence are crucial times for fostering good mental health and preventing the significant adverse impacts of mental illness on life. Even when mental illness is mild to moderate it can impair education and, consequently, labour market outcomes (Veldman et al., 2014).

Yet there is a considerable lack of awareness, non-disclosure and under-treatment among young people, with the gap between onset of a mental illness and the first treatment being about 12 years on average (Kessler and Wang, 2008).

The education system has an important role to play in the early identification of and support for children with mental ill-health. This chapter looks at how Austria approaches the challenge.

Although the country has a wealth of support mechanisms in place, they are often under-resourced and therefore of limited impact. A further concern is that mental illness is overrepresented among young people who leave school early or with low levels of educational attainment and who, consequently, struggle in the labour market. This chapter focuses particularly on recent innovations in Austria that emphasise case management and on the trend towards the gradual professionalisation of mental health support.

Gradually improving school support

In Austria, the federal and the nine regional governments share responsibility for education. The regions show significant disparities in their ability to foster good mental health and address students' mental health problems. Differences between schools within the nine regions may also be wide even though schools enjoy less autonomy in Austria than in other OECD countries.

Austria spends 5.8% of its GDP on education – slightly less than the OECD average of 6.3% (OECD, 2013). How, and how effectively, does it use that expenditure to ensure good education and labour market outcomes for disadvantaged children, especially those with behavioural problems and poor mental health?

Inclusion creates new challenges for mainstream schools

As in most OECD countries, schools for children with special needs used to be widespread in Austria. The EU's strong inclusion agenda is rapidly changing that practice, however. Today, most Austrian children with special needs attend mainstream schools (Table 4.1) where they

get extra support in the classroom – from, for example, integration teachers who typically have to deal with more than one child. Segregated special classes in mainstream schools are rare in Austria.

Table 4.1. **Austria has more students with special needs in mainstream schools**

Number of students with special education needs and the relative size of the special education system, academic year 2008-09

	Total number of students	Students with special needs as % of all students			
		All	In special education	In segregated special classes in mainstream schools	In mainstream schools
Austria	**802 519**	**3.6%**	**1.5%**	**0.1%**	**2.0%**
Belgium - Flanders[a]	863 334	6.6%	5.5%	-	1.1%
Belgium - Wallonia[a]	687 137	4.5%	4.5%	-	0.0%
Denmark	719 144	4.7%	1.8%	2.6%	0.3%
Netherlands[a]	2 411 194	4.3%	2.7%	-	1.6%
Norway[a]	615 883	7.9%	0.3%	0.9%	6.7%
Sweden[b]	906 189	1.5%	0.1%	1.5%	-
Switzerland[b]	777 394	5.4%	2.1%	3.3%	-
United Kingdom	9 297 319	3.4%	1.2%	0.2%	2.0%

a. The data for the Netherlands and Norway refer to the academic year 2009-10, and those of the Flemish Community in Belgium to the academic year 2010-11.

b. Sweden and Switzerland do not collect data on students with special education needs who are fully included in mainstream classes.

Source: OECD calculations based on data from the European Agency for Development in Special Needs Education (*www.european-agency.org* accessed 1 June 2015).

StatLink http://dx.doi.org/10.1787/888933239484

More recent Austrian data for the 2011-12 academic year show that the share of students with special education needs in mainstream schools had risen to 2.2%, and even up to 3% in regions where the trend towards inclusion has been fastest (Bruneforth and Lassnigg, 2012).

Special-needs education in Austria is provided during compulsory schooling only, up to the age of 15. Accordingly, children with special education needs almost never attend what are known in Austria as "academic secondary schools" or "colleges of higher secondary education". They are likely, therefore, to leave the school system with a relatively low level of educational attainment. (Figure 4.A1.1 in the annex illustrates the structure of the Austrian education system.)

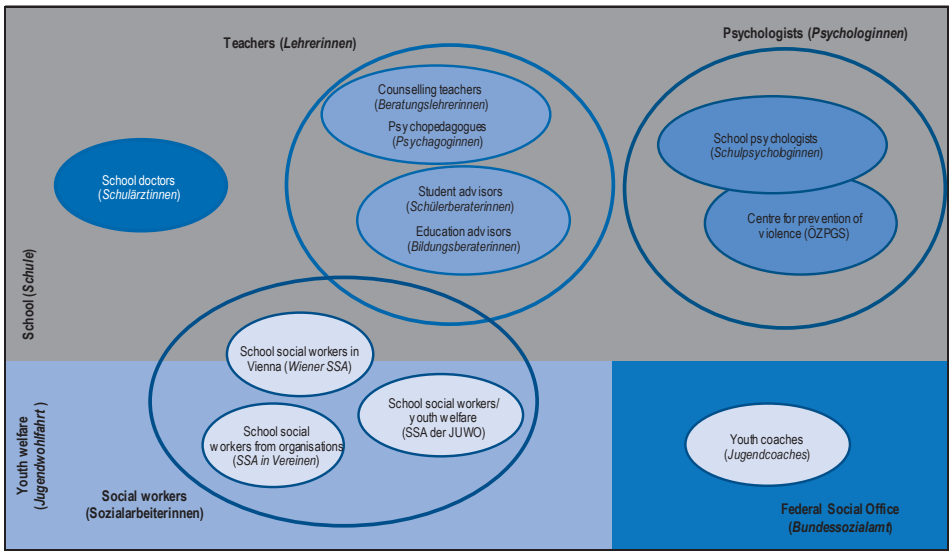
Special education needs are defined as those of a child who is ready for school but, because of physical or mental disability, cannot follow the regular curriculum without special support measures. Students are assessed to determine whether they are entitled to such measures. Those

who suffer from mild-to-moderate mental ill-health only rarely fall into the special-needs group and therefore receive the same support as everyone else. However, the shift to inclusive schooling comes with indirect advantages for students who exhibit behavioural and psychological problems insofar as mainstream schools now show increased awareness of differences in students' abilities. They also have greater resources and improved support skills for addressing them.

Support for teachers is expanding

It is widely understood in Austria that mental ill-health should be tackled early in life. Problems in school are felt to be growing for a number of reasons, such as the rise in the numbers of pupils whose behaviour problems make them difficult to handle, higher parent expectations, and the greater demands placed on schools generally. Students struggling with psychosocial behavioural issues can obtain help from a range of services. As part of their policies of inclusion in mainstream schools, the education authorities constantly upgrade the variety, quantity and quality of counselling on offer to schools.

Figure 4.1. **Psychosocial counselling at and for schools in Austria**



Source: Adapted and translated from the website of the Austrian school psychology service; www.schulpsychologie.at/schulpsychologiebrbildungsberatung/psychosoziale-beratung/ (accessed 1 June 2015).

In Austria there are tiers of counselling for students grappling with mental health problems which often follow a sequence – even though no regulation stipulates so. What actually happens depends on the

decisions taken at certain moments and the very different kinds of support available to schools (and regions). A crucial person in this context is the school principal. He or she it is who decides what steps to take and what support to seek. Misinterpreting mental illness as bad behaviour can easily lead to wrong decisions and courses of action – such as suspension from school.

Actors in the sequence of special needs support

Class teachers

First in line in the counselling sequence are teachers, especially class teachers, who are usually the first point of contact for students and parents. As far as possible, class teachers should, and often do, take responsibility for organising support that goes beyond what untrained teaching staff can offer. They need, therefore, to be well informed as to the high prevalence of mental ill-health in students, how to identify signs of illness, and how best to react. Teacher training to that end is not, however, widely available and certainly not mandatory.

Student advisors

The second stage in the mental health counselling sequence in Austrian schools is low-threshold intervention by teachers who have extra qualifications. Known as student or education advisor, they work as regular teachers in school most of the time, but with a portion of their contractual working hours devoted to helping students or advising on education. A school with, say, 800 students would typically have around four hours per week set aside for student/education advice.

Student advisors have a dual role – to provide information on education options and to help students with behavioural or learning problems. They may thus be first points of call for both students and parents, especially when pupils lack the trust to confide in the class teacher or are seeking advice on conflicts with a teacher. In total, there are about 1 100 student advisors in upper secondary schools and about 1 400 in lower secondary schools, but funding is restricted to around 100 full-time equivalents. These services are not, however, available for the first four years of schooling in primary school, where the class teacher plays an overarching role.

Psychopedagogically trained teachers

A third tier of support is provided by teachers whose training includes specialisation in psychopedagogy. Known as counselling

teachers or psychopedagogues, depending on the region and the training they have taken, they work full-time as psychopedagogues and go into schools when required (see Box 4.1). A school may typically have a weekly allotment of between 10 and 20 hours for psychopedagogically trained teachers each of who typically serve two schools. However, resources are not sufficient to provide such support in all schools.

Counselling teachers and psychopedagogues are employed by Special Education Centres, chiefly to help children with behavioural problems – often, though not always, linked to mental ill-health. The system differs across the nine regions and precisely because it is a regional matter, national statistics are unavailable. All regions together, Austria has around 440 psychopedagogically trained teachers in total.

Box 4.1. **Austria's "psychagogues"**

Austria's psychopedagogically trained teachers who provide support to troubled young people are a profession introduced about 40 years ago. They are known either as *Beratungslehrer* or *Psychagogen* ("psychagogues"). There is a slight difference in the type of training that *Beratungslehrer* and *Psychagogen* receive (as discussed in the text below).

Terminology notwithstanding, psychopedagogues are teachers who now receive intensive university-level training in psychoanalysis and in dealing with children who struggle with social, emotional and behavioural problems. They are not, however, allowed to call themselves psychologists because only professionals who trained as (school or clinical or health) psychologists may use this term.

Austria's psychopedagogues are currently looking for an appropriate term to designate their profession. Their aim is to find one that does justice to their abilities and training and makes clear that, although they are not psychologists, they are significantly better trained than student and education advisors. In the meantime, the neologism "psychagogue" fits the bill.

Depending on the region, some psychopedagogues also work in schools other than mainstream ones. Vienna, for instance, has an innovative arrangement that lies between mainstream and hospital schooling, where psychopedagogues groom a small number of children of pre-school age with serious emotional and behavioural difficulties for mainstream primary school. Grooming can last from one to three years, depending on the child's needs, and may be followed by a further one-to-two-year period of intensive support in the mainstream primary school to ensure that children find their place in school. Most such children come from broken homes, often with parents unable to care for them because of own poor mental health or substance abuse.

School social workers

The next, or rather parallel, avenue of support is school social work. In eight of the nine Austrian regions such support is provided through either youth welfare services or privately run non-profit organisations and associations. Because school social workers address common social and family problems they necessarily deal with many students who suffer from mental ill-health. However, only Vienna, in a recent move prompted by the belief that social workers should always be on hand, has moved them into schools and put them under the responsibility of the regional education authority (Piringer et al., 2011).

Qualified school social workers study for three years at the Academy of Social Work. But there are only around 70 school social workers available who struggle to meet demand. Austria has responded in recent years by seeking to make them more effective. July 2013 saw the publication of a comprehensive guide designed to support the implementation of school social work (Lehner et al., 2013).

School psychologists

The next step in the mental health support chain (though it often comes before action by psychopedagogues) comes in the shape of professional support from school psychologists.

School psychology is a long-established discipline in Austria, practiced by clinical psychologists with a university-level degree. The country's 160 school psychologists operate through a network of 76 counselling centres. They are not doctors or psychotherapists and may not provide treatment. Their main tasks are:

- psychological counselling and advice for students, teachers, parents and school authorities
- diagnostic profiles of students in order to identify, for example, dyslexia or dyscalculia
- individual support and basic intervention in crisis situations.

There are also a further 45 school psychologists available in Austria whose job is to prevent violence.

With the resources available to them, school psychologists are able to reach about 5% of the student population. Of that percentage some one-third suffer from mental ill-health, although is estimated that as many as 15% may need mental health support.

Youth coaches

Youth coaches are a further – recent – addition to Austria's support provision for school children. Their job is to keep young people in the education system and ensure their transition into the labour market – a topic this chapter discusses in greater detail in a later section. Currently there are around 350 youth coaches who support Austrian schools.

School doctors

The final link in the support chain is school doctors, although they are largely outside the counselling loop. Like psychopedagogues, they come into schools regularly (typically once or twice a week), with each school doctor servicing several schools and their number depending on the size of the establishment.

Their role can include helping students with psychological problems but, like general practitioners, their medical training actually contains very little to do with mental health. Nor does regular pupil health screening in schools include any mental health component.

The way in which mental health support services are delivered in Austria in reality may often be very different from the theory. It depends on the availability of different kinds of supports (which in turn depend on the school and region), on the nature of a problem, and on how urgent it is. Typically procedures kick in much faster when there are issues of aggression and possible injury, whereas students with internalising mental health disorders may often receive support only at a rather late stage or not at all.

Support is insufficient and lacks case co-ordination

Despite the continuous expansion in its wide array of school support services, internationally comparable data from the OECD's 2008 Teaching and Learning International Survey (TALIS) suggest that Austria ranks poorly when it comes to what TALIS broadly defines as professional pedagogical support staff. Indeed, it brings up the rear in a comparison of 18 OECD countries. In Austria, there is one teaching support professional for every 24 teachers, compared to an average of 1/14 and even 1/7 in countries like Australia, Hungary, Poland and the Nordic countries (Table 4.2). In Austria the typical school thus has only one support professional, compared with six in Denmark or Norway, for example (Schmich, 2010).

Table 4.2. **Austria does not provide enough pedagogical support for teachers**

Average class sizes and staff-to-teacher ratios in lower secondary education, 2010

	Average class size (lower secondary education only)		Ratio of teachers to number of school administrative or management personnel		Ratio of teachers to number of personnel for pedagogical support	
Countries	Mean	(Standard error)	Mean	(Standard error)	Mean	(Standard error)
Australia	24.6	(0.20)	5.5	(0.30)	8.3	(0.61)
Austria	**21.1**	**(0.14)**	**22.6**	**(0.82)**	**24.1**	**(1.08)**
Belgium (Flanders)	17.5	(0.27)	11.7	(0.73)	20.5	(1.63)
Denmark	20.0	(0.22)	7.5	(0.38)	9.1	(0.97)
Estonia	20.5	(0.32)	7.6	(0.21)	10.4	(0.69)
Hungary	20.2	(0.57)	8.3	(0.48)	7.3	(0.69)
Iceland	18.6	(0.02)	6.3	(0.22)	5.7	(0.60)
Ireland	21.9	(0.18)	11.1	(0.41)	15.8	(1.06)
Italy	21.3	(0.16)	7.5	(0.32)	20.4	(3.22)
Korea	34.6	(0.43)	4.9	(0.32)	14.0	(1.12)
Mexico	37.8	(0.55)	5.0	(0.34)	7.9	(0.68)
Norway	21.4	(0.29)	8.3	(0.31)	7.0	(0.41)
Poland	20.8	(0.27)	9.0	(0.48)	9.4	(0.56)
Portugal	21.3	(0.21)	10.5	(0.59)	10.8	(1.64)
Slovak Republic	21.1	(0.26)	4.7	(0.17)	14.3	(1.15)
Slovenia	18.8	(0.18)	7.8	(0.34)	18.3	(1.16)
Spain	21.7	(0.26)	8.8	(0.68)	19.0	(0.91)
Turkey	31.3	(0.75)	10.4	(0.49)	22.2	(2.53)
Average	***23.0***		***8.8***		***13.6***	

Note: These data are the mean values of the schools where lower-secondary school teachers work. The education provision in such schools may extend across ISCED levels (e.g. in schools that offer both lower and upper secondary education) and is not necessarily restricted therefore to teachers or students in lower-secondary education only.

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

StatLink http://dx.doi.org/10.1787/888933239495

Switch focus and resources to support staff

While the support staff provision has grown over time in Austria, as it has in the rest of the OECD, the chief development over the past 30 years or so has been the expansion in the number of teachers. The total student population has fallen by around 15% while the number of classes has remained unchanged and the number of teachers has risen by around 25%. As a result, class sizes have dropped from close to 30 to just over 20, and the number of students per teacher has halved from 20 to around 10 (Bruneforth and Lassnigg, 2012).

The trend towards a lower pupil-to-teacher ratio is much more pronounced in Austria than in other OECD countries and leaves considerable room for shifts in focus and resources. There is a strong case for gradually reducing the number of teachers in the coming decade and gradually increasing professional pedagogical support staff.

The small number of support professionals in Austria is partly a result of the way the education system is funded and structured. Schools have some autonomy in use of the resources allocated to them for teaching and support staff, which may prompt them to maintain and increase the number of teachers instead of strengthening professional support staff. School principals must show strong leadership to resist that tendency, particularly as most of them know there is a need for additional support from qualified professionals. Indeed, the 2008 TALIS survey found that between 70% and 80% of all school principals thought teaching at their schools was negatively affected by a shortage of school psychologists, psychopedagogues and social workers (Schmich, 2010).

As support staff numbers grow, boundaries become blurred

The expansion in the range of support can, however, give rise to problems in such closed organisations as schools that lack a culture of seeking help and may resent counselling from outside. They may, for example, regard psychopedagogues as advocates of difficult students who leave the needs of class teachers unaddressed. Better integration of pedagogical support within schools would help address such resentment. One way forward could be Vienna's school social work model, where social workers are present in school all year round, are paid just like teachers, and formally answer to the same authority.

The blurring of roles is another issue in two ways. First, it is not always clear to a student or parent who the best point of (first) contact is – the class teacher, the student advisor, the psychopedagogue, the school psychologist, or the youth coach?

The second issue is that support professionals themselves may be unclear as to their roles. The recent new focus on school social workers, for example, is creating uncertainty among counselling teachers and psychopedagogues as to their overarching responsibility. Similarly, youth coaches may be seen as robbing other professionals of their responsibilities. Clearly delineating roles and fostering co-operation among all support professionals may go some way towards addressing conflicts and confusion.

Co-operation between teaching professionals is essential

Co-operation is traditionally close between school psychologists and student advisors – the two oldest counselling professions put in place at around the same time. Between school psychologists and psychopedagogues, however, co-operation could be more effective, and both professions have yet to work out where they stand in relation to the latest developments – the focus on school social workers and the introduction of a network of youth coaches. The scarcity of resources makes closer co-operation especially important. One possible inference is that some of those scant resources should go to improving co-operation in order to avoid duplication and maximise impacts.

Behind all co-ordination issues lies the all-pervading need for multidisciplinary support. The solution would be an expert who is permanently on-site and acts as a case manager to secure a smooth interface between the different support services available in and for a school. It has yet to be clarified who would be best placed to take on such a role, particularly as the combinations of support staff available differ from region to region and school to school.

Against that background, the weak interface with the health system also needs strengthening in order to ensure adequate mental health treatment for those who need it. Treatment cannot be provided by psychopedagogues, school psychologists, and school social workers, yet there is little collaboration between the education and the health systems.

Child and youth psychiatry is an underdeveloped and relatively new field in Austria, even though a particularly high proportion of psychologically unwell children and adolescents are undertreated (see Chapter 5). Estimates suggest that only between 10% and 30% receive any support or treatment, and less than 10% benefit from specific therapy (Vesely, 2013). Child psychiatrists and other doctors (e.g. GPs and paediatricians) should work closely with schools. Doing so would be in the mutual interest of both doctors and schools: For doctors, because school is the best setting for the early identification and care. For schools, because child psychiatry can help them to assess the actual needs of students with mental ill-health and offer them the best possible support. Finally, child psychologists can provide treatment that takes school needs into account.

Towards more professional support services

An important trend afoot in Austria for some time now has been the gradual professionalisation of the pedagogical support services provided in schools. Almost all types of support are concerned.

- School psychologists are now trained clinical psychologists, whereas they were once teachers with a special qualification. Accordingly, their role has changed and broadened significantly over time.
- Although student advisors are still teachers who have an additional qualification, the bar for obtaining that qualification was recently raised. Nevertheless, it still equates only to 12 European Credit Transfer System (ECTS) credits – still less demanding than it is for other support professionals and in other OECD countries.
- Psychopedagogical training, too, has been stiffened. The courses at teacher training college last two years and the number of ECTS credits required to qualify have gradually been raised to between 65 and 80, depending on the region. Some regions – like Vienna – recently went a step further in professionalising psychopedagogical support through the introduction of a three-year university-level course that converts to 120 ECTS credits.[1] Continued funding for this more intensive programme, however, has yet to be secured.
- Social workers bring additional, hitherto unavailable, professional support into the schools, just as youth coaches – who are usually social workers and sometimes psychologists – eventually will, too.

Teacher training gives little grounding in mental health support

When it comes to teachers, who play a critical role in school-based psychological counselling in Austria, however, little has been done to professionalise their mental health know-how.

There should be greater focus on mental health awareness in the regular teacher training curriculum and more continuous training opportunities in that area for teachers currently working. The forthcoming professionalisation of programmes in teacher training colleges – which will include extending them from three to four years – clears the way for future teachers to receive better training.[2] As part of the reform of primary and lower-secondary school teacher training, there are plans to enrich the curriculum with an inclusion focus. This will be a valuable addition to further improvements through awareness training for current teachers.

Teachers would also stand to gain from being better supervised in difficult situations, a provision that is not widely available. Professional support workers could give teachers more coaching rather than focusing solely on the needs of students. Supervision of support professionals like psychopedagogues is also important, though it is not available as widely as necessary – there is some group supervision, but very little individual and case-specific supervision.

New efforts to foster school completion

Although psychological problems and mental illness are likely to be strong factors in poor school attendance and early drop-out, there is only very limited evidence to that effect. According to OECD (2012), which draws on data from the Eurobarometer 2010, 27.5% of all young Austrians with a mental health complaint have stopped full-time education by the age of 15, with no difference between those who suffer from mild-to-moderate and severe disorders. The Austrian percentage is higher than the 21.5% average observed across 21 EU countries. The shares among young people who do not suffer from mental ill health are eight percentage points lower, both in Austria and, on average, in the 21 EU countries.

School completion is crucial for later labour market success

Poor education leads to poor labour market opportunities. Helping students to achieve an academic standard that matches their cognitive abilities and capacity is critical. Many young people grappling with mental health problems in the midst of their adolescence, or earlier, struggle to fulfil their educational potential.

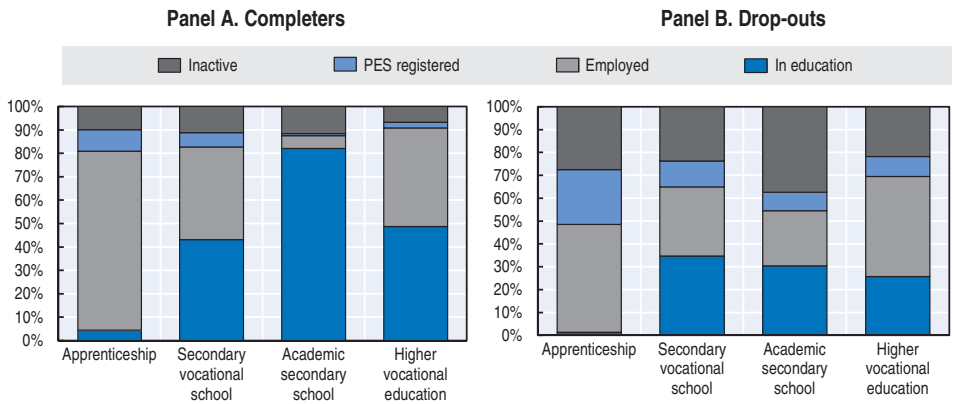
Recent education monitoring by Statistics Austria shows just how important completion of education is to labour market outcomes. Of young people who completed an apprenticeship (typically at 18 years old), more than three out of four had a job 18 months later and only 10% were inactive – the remainder being either in education or registered as jobseekers. Of the 15% who ended their apprenticeships prematurely, only one-half held a job 18 months later (Figure 4.2). The difference cannot be explained by the negligible number of apprentices seeking to continue their education elsewhere, as a quarter are registered as unemployed and another quarter are inactive.

The findings for all other types of schooling are equally telling, even though labour force distribution differs according to the kind of establishment. Young people who break off their secondary vocational

schooling (one in five drop out) are less likely to find a job or to continue education and twice as likely to be unemployed or inactive 18 months later. As for higher vocational schools and academic secondary schools (see Figure 4.A1.1 in the annex for a description of the Austrian education system), those who drop out are three to four times more likely to be inactive or unemployed than students who stay on. While over 80% of students who complete academic secondary school are still in education 18 months later (often tertiary), the share falls to just 30% among those who leave prematurely.

Figure 4.2. **Completing education increases employment potential significantly**

Labour force status 18 months after completing or dropping out of education in school year 2009-10



Source: Statistik Austria, Bildungsmonitoring, www.statistik.at/web_de/statistiken/bildung_und_kultur/bildungsbezogenes_erwerbskarrierenmonitoring_biber/index.html (accessed 1 June 2015).

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Young people with a mental disorder are not only more likely to leave school early but they are also more likely to struggle in their transition to the labour market after cutting short their education. The Austrian education drop-out rate is highest in secondary vocational schools – particularly in the first year, which also happens to be the last year of mandatory schooling. Similarly, apprentices are more likely to drop out than students in upper secondary education.

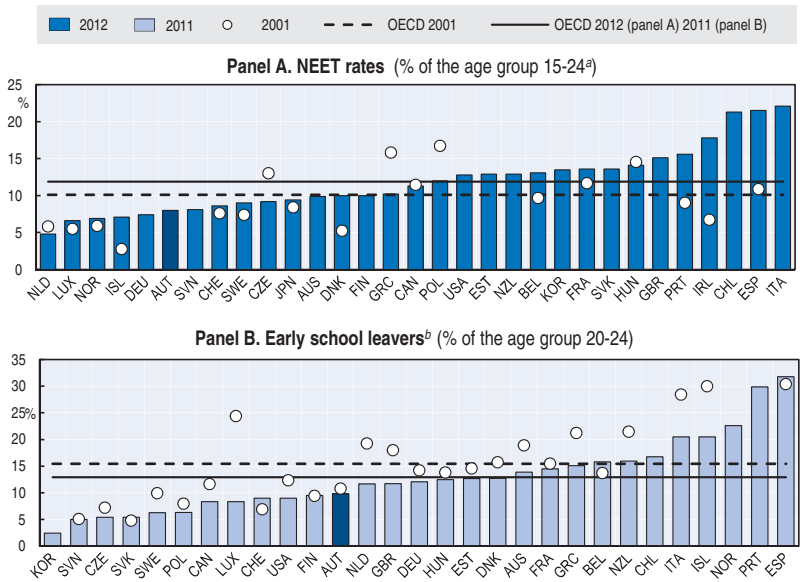
Austrian education outcomes are good but improvement is slow

Overall education outcomes appear to be relatively good in Austria:

- At 8%, young people not in employment, education or training (NEETs) account for a smaller share of young people than the OECD average, largely because of Austria's stronger labour market and lower youth unemployment (Figure 4.3, Panel A).
- At 9% the share of early school leavers – defined as young people aged 20-24 no longer attending school and having left education without an upper-secondary degree – is also below both the OECD average (though only just) and below the 2020 EU-target of 9.5% (Figure 4.3, Panel B).

Figure 4.3. **Education outcomes in Austria are better than average but have not improved in the past decade**

Key education indicators for young people aged 15-24 years old, 2001 and 2011/12



NEET: Not in employment nor in education or training.

Note: OECD is an unweighted average of the countries in each panel.

a. The age range for Sweden, the United Kingdom and the United States is 16 to 24 years old.

b. The number of young people aged 20-24 years old who are not attending school and have not obtained an upper secondary education compared to all 20- to 24-year-olds.

Source: *OECD Education Database*, www.oecd.org/edu/database.htm (accessed 1 June 2015).

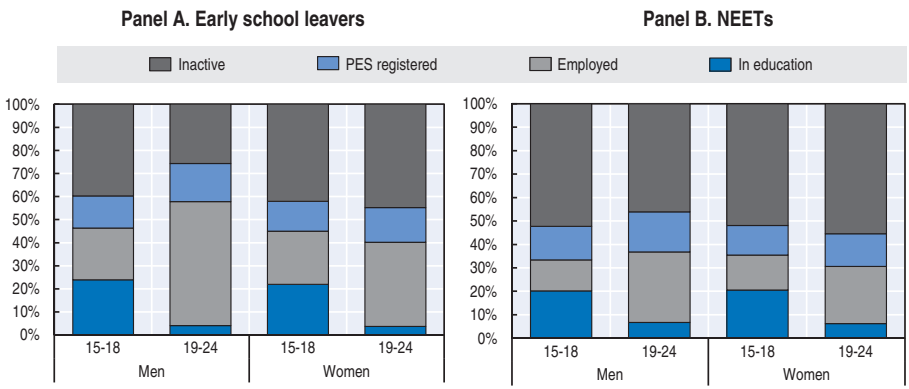
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Although young people's labour market outcomes are relatively sound, nearly one in ten in every cohort misses out. Two issues further cloud the picture. First, shares of NEETs and drop-outs have stayed pretty much unchanged since around 2000, with the number of early school leavers starting to fall slightly only in the past two years. Second, young people from certain pockets of the population are much more likely to fall into one or both groups. Typically, they are from families that are problematic and have a low socio-economic status – characteristics that naturally heighten mental health risks among children. Such issues have to be addressed.

Education monitoring by Statistics Austria also tracks NEETs and early school leavers to appraise their labour market outcomes 18 months down the road. The findings leave no doubt: both groups struggle to gain a foothold in the labour market. Only one-quarter of NEETs and one-third of early school leavers had found a job in the subsequent 18 months (Figure 4.4). Few of them return to education after the age of 19. Around half of the total group – just above 50% of NEETs and just below 50% of early school leavers – were inactive and not seeking a job. Only about one in seven was registered with the public employment office as a jobseeker – a share that was no higher among the 19-24 year olds than among 15-18 year olds.

Figure 4.4. **Only a minority of NEETs and early school leavers find a job within 18 months**

Labour market status of early school leavers and NEETs 18 months after 31 October 2010



NEET: Not in employment nor in education or training.

Source: Statistik Austria, Bildungsmonitoring, www.statistik.at/web_de/statistiken/bildung_und_kultur/bildungsbezogenes_erwerbskarrierenmonitoring_biber/index.html (accessed 1 June 2015).

StatLink http://dx.doi.org/10.1787/888933239312

Youth coaching to help young people stay on at school

There are two complementary ways to help NEETs and early school leavers. One is through measures that help them transition to the labour market (as discussed in the next section). The other is by addressing early school leaving itself and ensuring a higher share of each cohort completes education to a standard in line with their ability.

The purpose of the multiple pedagogical support provisions discussed at length above is to give students fast, appropriate backing and guidance when needed, thereby helping – at least indirectly – to prevent them from slipping out of the education system. Until recently, no interventions had targeted drop-out prevention.

In January 2012, the federal government trialled a new scheme called Youth Coaching in two of Austria's nine regions. Building on experiences from earlier programmes (such as "Clearing", introduced in 2001), the scheme is now available throughout Austria. Its aim is to help young people stay on in education (see Box 4.1). Some key, and even unique, features of Youth Coaching are:

- Early detection of problems to enable early intervention.
- Flexibility through a three-step process to ensure that young people at risk receive the degree of support needed.
- Case management by youth coaches to ensure other pedagogical support professionals network and co-operate effectively.
- It is a national programme that is funded nationally and operated in the same way all over the country.

In its trial phase, Youth Coaching was primarily directed at students in the ninth year of compulsory schooling – the target group easiest to reach through notification by their class teachers. If youth coaches are to reach out more successfully to other target groups, such as NEETs, they will need to find more effective methods which should include close collaboration with other actors (e.g. youth workers).

Nevertheless, initial evaluation suggests that of the school children who took part in the scheme only 7% dropped out, while the remaining 85% achieved outcomes in line with the targeted agreement (Steiner et al., 2013). Some 30% ended up in Step 3 – the most intensive counselling level which uses case management. Among NEETs, a target group that Youth Coaching has not yet addressed, the share needing intensive support will be much higher, which will raise

significant funding issues in the future. Adequate funding is critical in view of youth coaches' heavy caseload of some 100 students.

A final positive point to emerge from the trial was that there seemed to be little overlap with the existing support provided by social workers, school psychologists, psychopedagogues and student advisors for children with mental and behavioural problems. The existing support had apparently not been affected when Youth Coaching was introduced. Youth coaches seem well placed to act as hubs for the support provision for students at risk – though such a role would require full recognition from other support professionals.

Box 4.2. **Youth Coaching to help young people stay in the education system**

The aim of the Youth Coaching scheme, introduced in 2012, is to help young people stay in the education system as long as possible and to bring NEETs back into education and training. The three target groups are:

- Students in their ninth (and last) year of compulsory schooling, who are typically between 15 and 16 years old;
- NEETs under the age of 19;
- Young people with disability or special education needs under age 25.

Young people in the target groups typically struggle with individual and social difficulties and are at a high risk of failing to complete school. Youth coaches access those in their last year of school mainly through teachers who spot that they are at risk. They reach out to the two other target groups through a range of institutions and professionals (employment service, youth workers, youth welfare services). An important element of the programme is the involvement of both parents and teachers and a strong focus on the student's resources.

Actual coaching is a three-step process:

- Following an initial consultation to gather basic information, Step 1 begins. It is a three-hour counselling session designed to produce a target agreement and where all parties (student, parents, teacher and coach) decide whether going on to the next step is useful.
- Step 2 comprises eight hours of education counselling over a period up to three months. It is particularly designed for directionless young people with education deficits and may include, where necessary, outside professionals like social workers.
- Step 3 involves individually managing young people with multiple problems. It comprises more than 30 hours over a period that may be as long as a year. It works in clear steps towards implementing the target agreement decided in Step 1 and concludes with a clearance report. Youth coaches connect the young person with specialised support services – e.g. debt management advice or psychological counselling – and organise psychotherapy, if necessary.

Youth Coaching is not the only programme in Austria to address school drop-out, but it is the first to acknowledge and directly tackle mental health issues among young people at risk of dropping out. It is also the first scheme to be rolled out nationwide. Hitherto regions addressed premature school leaving in different ways. Vorarlberg, a small region on the Swiss border, for example, has a promising regulation that could be adopted by all regions: an early warning system with mandatory notification of the public employment service to help prevent young people from slipping out of the system for too long.

Youth Coaching can also not be the end of the process, as is well recognised in Austria. Beginning in early 2014, several regions have introduced follow-up pilot projects called "AusbildungsFit", targeted at youth under age 21 (or age 24, if having a disability) who completed Youth Coaching. The aim of this programme is to prepare youth for the next step(s) by improving basis education and social competences. The main pillars of the programme are coaching, training, knowledge workshops and sports. The coaching component includes psychological counselling. The programme can last up to a year. Referral is only through Youth Coaching or by the public employment service.

Facilitating the transition into the labour market

Young people with mental health conditions are among those who struggle most to find a job – because they are often poorly educated, come from families that are unable to give them support, and do not know how to go about seeking adequate work.

Relatively good labour market opportunities for Austrian youth

Young people in Austria enjoy a labour market situation that is generally better than in most other OECD countries. The youth unemployment rate is just under 10%, compared with an OECD average of 20% and levels of over 30% in some European countries (Figure 4.5, Panel A). However, even in Austria unemployment has deteriorated since the beginning of the Great Recession, and continues to do so. Youth unemployment is now almost 2.5 times as high as among adults, whereas the ratio was only 1.5/1 prior to the crisis.

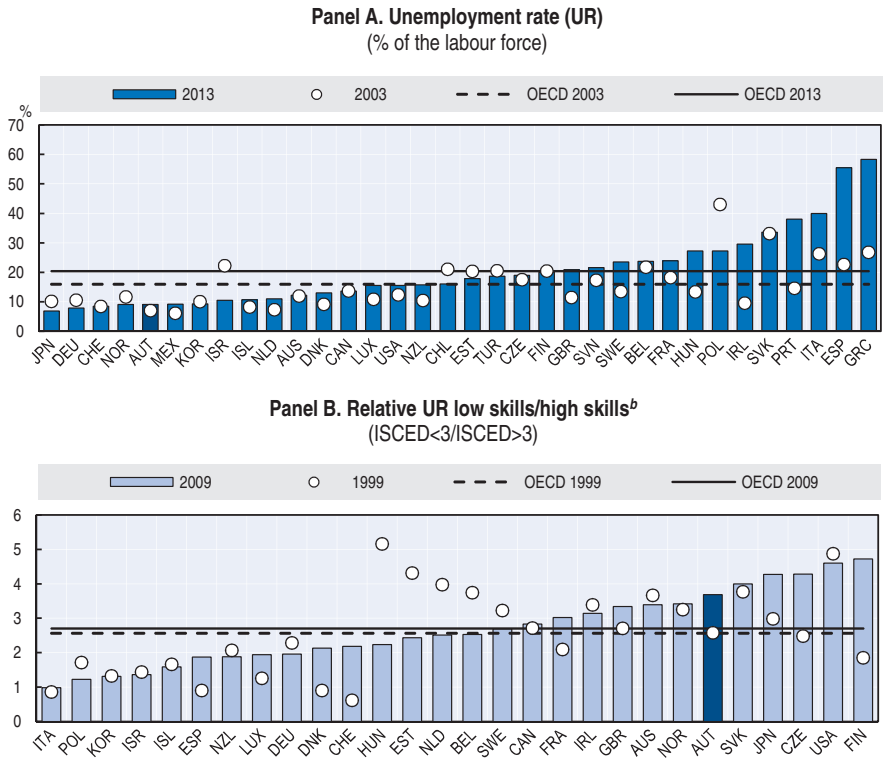
More important, though, is that unemployment and the fall-out from the crisis do not affect all young people in the same way. The unemployment rate among young people with low levels of educational achievement (those without upper secondary education) is now 3.5 times higher than among the highly skilled and educated. The ratio

has increased significantly in the past decade and is now among the highest in the OECD (Figure 4.5, Panel B).

The main challenge for poorly educated young people is that they have to contend with a combination of problems – poor education outcomes, weak family support and mental ill health contribute to notably poorer labour market prospects.

Figure 4.5. **Labour market prospects for young Austrians have worsened**

Key labour market indicators for young people aged between 15 and 24[a], latest year available



Note: OECD is an unweighted average of the countries in each panel.

a. Young people aged between 16 and 24 for Sweden, the United Kingdom and the United States. For Iceland up to 2008, Italy after 2009, Norway up to 2005 and Sweden up to 2006.

b. The unemployment rate of persons who have not attained upper secondary education divided by the unemployment rate of those who have attained upper secondary education

Source: Panel A: *OECD Database on Employment*; Panel B: OECD (2010), *Off to a Good Start? Jobs for Youth*, Table 2.1, OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264096127-en.

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Many Austrians leave the education system before the age of 19

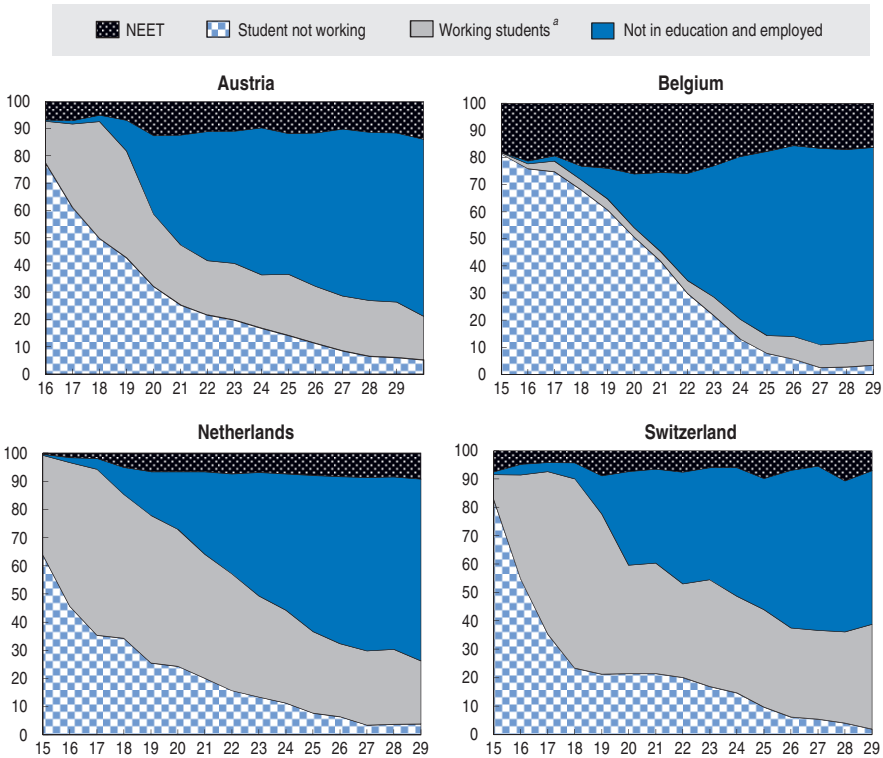
How easy is the transition into the labour market for young Austrians? As with several other indicators, nothing unfortunately is known about how young people with mental health conditions are doing in this regard compared with their psychologically sound peers.

Generally, the school-to-work transition appears relatively smooth for Austrians (Figure 4.6). There are fewer NEETs than in many other OECD countries, though their number grows after the age of 18, albeit only slightly, when Austrians usually complete their upper-secondary or workplace-based vocational education. With more than every second student starting an apprenticeship after mandatory schooling, almost 50% are already working by the age of 17. Many Austrians actually seek their first job with significant workplace experience, irrespective of the age at which they start looking. That said, at between 60% and 70% that share is even higher in the Netherlands and Switzerland, two other OECD countries with low youth unemployment.

The biggest challenge in Austria seems to be that many students leave the education system early: the share of students falls sharply between the ages of 18 and 20, faster than in other OECD countries. The system creates many mid-skilled but few highly-skilled workers, as reflected in the relatively low share of the population, until recently, that had obtained a post-secondary degree. There is an important role for continuing education and training that caters for young people who drop out of school because of poor mental health and those who end up in vocational education as a consequence of the Austrian education system's early streaming. Many of those who, at the age of 10, are directed into the lower stream of secondary school do not reach the upper-secondary level, thereby failing to achieve their full potential (OECD, 2011). In view of the early onset of many mental illnesses, especially anxiety disorders, children with mental ill-health may be disproportionately affected by early streaming.

Figure 4.6. **Age 20 we go: The school-to-work transition in Austria**

Educational and working status by age: full-time students, working students, employed, and not employed and not in education (NEET), selected countries, 2009



a. Including apprenticeship and other work-study programmes.

Source: OECD calculations based on the European Labour Force Survey 2009.

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Low-skilled young people struggle to find work

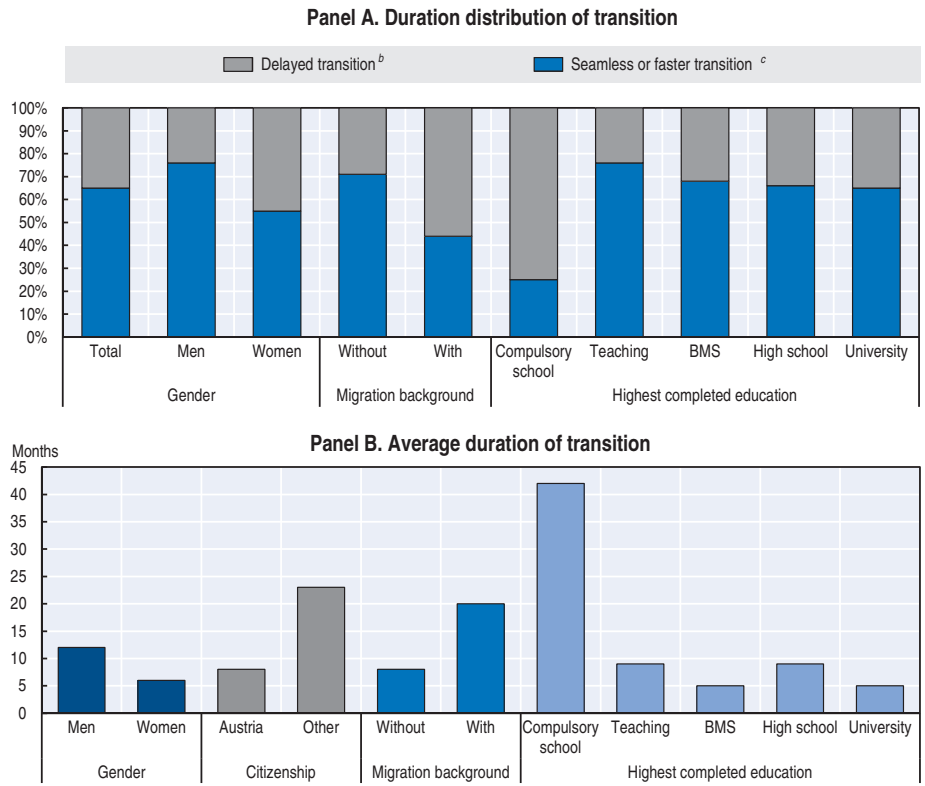
The school-to-work transition in Austria works comparatively well because of the good labour market conditions that have prevailed over several decades (although the crisis has made the situation worse than ever before) and because many young people have considerable workplace experience when entering the labour market.

Nevertheless, it is not easy for everyone to find a job quickly. Two-thirds of all young Austrians aged 15-34 find their first job within three months, more men than women even though women actually transition faster (Figure 4.7, Panels A and B). However, there is a big

divide when it comes to educational attainment. Of young Austrians who leave school after completing compulsory education, just one-quarter find their first job within three months. On average, it takes them as long as 42 months – a reflection of the waning demand for low-skilled workers. Across all other education groups, job-search duration is between 5 and 10 months. Accordingly, Austrians with a migrant background also struggle because of their poorer education achievements.

Figure 4.7. **Better educated young people and those with no migrant background find their first jobs faster**

How quickly young Austrians find their first job, by selected individual characteristics[a]



a. Young people aged 15-34 who have completed their training and live in private households.

b. Transitions of more than three months after completing education (excluding persons who reported military service as their main activity during the school-to-work transition).

c. The first job was started before or on completion of education, or within a maximum period of three months thereafter.

Source: OECD calculations based on the Labour Force Survey 2009 (Statistik Austria, 2009).

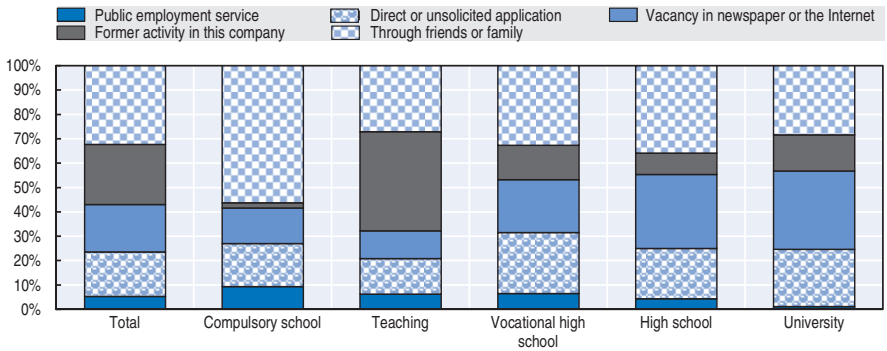
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Job searches that last several years are problematic because first-job experience is so important to triggering a fulfilling labour market career. Young people with poor mental health – over-represented in the low-skilled population – soon grow particularly discouraged. Years of fruitless job hunting will put more stable young people, too, at a much greater risk of developing a mental health problem.

More detailed information on how young Austrians find their first job illustrates the bleak job opportunities for young low-skilled jobseekers. More than half do so through friends and relatives and almost none through previous work experience, simply because most do not have any (Figure 4.8). Public employment services apparently do little to improve matters. Only 9% of low-skilled young jobseekers find their first job with the help of the PES, scarcely more than among better educated groups who are much less dependent on the PES.

Figure 4.8. **Friends and relatives play an important role in helping low-skilled young people find their first job**

How 15-34 year-olds find their first job, by level of completed education



Source: OECD calculations based on the Labour Force Survey 2009 (Statistik Austria, 2009).

StatLink http://dx.doi.org/10.1787/888933239356

The PES has a key role in labour market transitions

The PES has a key role to play in preventing disadvantaged and low-skilled young people with mental health problems from finding themselves permanently inactive. In this regard, the Austrian PES faces a twin challenge:

1. Help NEETs and early school leavers who struggle to find work.
2. Address mental health problems, often the biggest labour market barrier among NEETs and early school leavers.

Poor mental health remains an unsolved challenge for jobseekers of all ages (see Chapter 2), though it is a particular – and common – concern among young jobseekers in view of its early onset.

The Austrian PES is increasingly recognising its key role and endeavouring to intervene earlier and provide disadvantaged young people with stronger support. Supplying information on jobs and the labour market has been one of its roles since the 1990s. The chief targets are students in the 7th and 8th grades – i.e. before the last year of compulsory schooling and the transition to upper-secondary education or an apprenticeship – and the PES has strengthened its co-operation with schools over the years in that regard. However, providing information through relatively short-lived group workshops and visits to companies falls short of the needs of students with mental ill- health. They require more closely targeted, individual interventions.

Special measures to ease the school-to-work transition

A number of developments in the PES's efforts to ease labour market transitions are worth emphasising.

Apprenticeship guarantees (Überbetriebliche Lehrlingsausbildung)

For a few years now, young Austrians have benefitted from a scheme known as the Apprenticeship Guarantee. It ensures a PES-funded apprenticeship for young people who have completed their education but cannot find a regular apprenticeship on the labour market and for those who have pulled out of an apprenticeship and have registered with the PES. The aim is to deliver an apprenticeship during the school-to-work transition and a job in the desired field afterwards. The guarantee ensures that no one falls through the cracks.

An evaluation of the measure found that both trainers and trainees who completed the course were very satisfied. Those who drop out do so chiefly because they do not want to continue training for a particular trade. Personal and health problems also account for about one-quarter of all drop-outs (Lenger et al., 2010).

Inclusive Apprenticeship Training (Integrative Berufsausbildung)

Inclusive Apprenticeship Training was introduced roughly 10 years ago. It targets young people who suffer from a disability, have special education needs, have not completed their education, or face other job placement barriers.

Inclusive Apprenticeships extend vocational apprenticeships to four years (instead of three) and part-qualify apprentices for particular jobs. The PES funds companies that offer Inclusive Apprenticeship Training places and provides targeted assistance, both social and psychological, to ensure apprentices complete their training.

Evaluation showed that by 2007 some 3% of all apprentices were in Inclusive Apprenticeship Training, of whom two-thirds were special-needs registered. Completion rates were high, especially among those who opted for partial qualification and (at the time of assessment) two-thirds of those who had completed their training were employed by the same employer afterwards (Heckl et al., 2008).

Apprentice Coaching

Apprentice Coaching is a scheme similar to Youth Coaching (see above) that was recently introduced by the Austrian government. Just like youth coaches, apprentice coaches advise and support apprentices and the enterprise they are working for to ensure they successfully complete their apprenticeships. They also help find solutions when problems arise. Apprentice Coaching targets young people who fail to complete their education and are registered jobseekers but also those who have special education needs. In both groups, poor mental health is widespread.

The measure is still in its pilot phase and no evaluation is available as yet. It could plausibly be expanded to all apprentices who need coaching to lessen their chances of dropping out.

Factory schools

The PES is also involved in non-traditional schooling schemes for students who leave school without qualifications and cannot cope with school or apprenticeships in their current form. It partners with several Austrian regions to run "factory schools" for 15-25 year-olds. They emulate Denmark's factory schools which have now gained full recognition as schools in their own right. More flexible than mainstream schools in their curriculum and duration, they focus strongly on behavioural stability and key competences (Platzer, 2014). They seek to be a viable alternative for students who suffer from social and emotional problems.

School-to-work transition measures disregard mental health

However, in none of its efforts (longstanding or recent) to address young people's trouble completing school and transitioning to the labour market does the PES put much focus on problems of health, particularly mental health. If the above schemes are to be more successful in helping young people make the transition from school to work, the PES must give greater attention to health as well as social barriers, show a better grasp of underlying undisclosed health issues, and develop greater psychological expertise.

Avoiding long-term reliance on disability benefits

Unlike many other OECD countries, Austria does not face a problem with large and growing numbers of young people accessing disability benefit because of mental disorders. Generally speaking, it is not easy to qualify for disability benefit because eligibility requires five years of insured employment in the previous ten. Workers under 27 years old, however, can in principle qualify for benefit after six months' work during which they contribute to social insurance.

Yet there are only slightly over 300 new claims from the under-24s every year, all granted temporarily initially. Less than 200 of those claims are for mental disorders. Although the number has increased lately, it is still very small and likely to fall as a consequence of the 2013 disability reform which confines disability payments to people fully and permanently unable to work.

Social assistance benefit (BMS), however, is important for young people in Austria. Roughly one in four adult recipients of BMS is younger than 30 and the under-20s (not counting dependent children) account for 5% of the total caseload. The latest data suggest there are currently around 6 500 BMS claimants under age 20 and over 30 000 under age 30, with numbers gradually increasing over the past decade in all age groups. Moving off BMS and into work is a particular challenge for young claimants, not least because the financial incentives for doing so are slight and job and earnings prospects poor.

Activating young people on benefit to prevent permanent benefit receipt is a daunting task. Following recent benefit reforms discussed in Chapter 2, the task will fall almost exclusively to the PES. The success of the PES in retraining and placing (potential) benefit claimants will determine the success of the benefit reforms. A particular effort will be required to activate young BMS claimants who, if certified as being ill,

will be exempted from job-search – often for relatively long periods – without the PES doing much about it.

BMS recipients have to register with the PES whose task it is to stimulate them to actively seek work. It is a relatively new role and the PES has yet to gain experience in addressing the complex problems that many young people on social assistance benefit face. Job-seeking exemptions are often the worst solution because they waste valuable time during which activation might have been fruitful.

The PES needs to act quickly and rigorously when it comes to young BMS recipients (see also Chapter 2). One way is to prevent their claims by addressing their needs earlier through some of the measures discussed in this chapter. The PES must co-operate closely with schools and local authorities to intervene swiftly when students are about to drop out from education or have done so already. More effective collaboration with the health system, too, is required if the PES is to support young jobseekers unable to make the transition into higher education and the labour market because of social, emotional and mental health problems. The PES not only needs to be willing and able but sufficiently resourced, too, to perform its multiple roles, some of which are new. Only then will it be possible to successfully integrate more young people with mental health problems into employment.

Round-up and recommendations

Austria has a strong labour market with low youth unemployment although the situation has worsened recently, especially for low-skilled youth. The share of both NEETs and early school leavers is, at just below 10%, lower than the OECD average, but with little improvement in the past decade.

In general, little is known in Austria about how youth with mental ill-health fare in education and the labour market transition, because such problems are not identified or measured anywhere in a systematic way. However, there is a broadly shared appreciation that mental ill health problems should be addressed early in life and that they seem to be surfacing in more and more adolescents. Policy developments reflect that understanding in various ways.

First, Austria has a range of support arrangements in place to help schools and teachers. It has expanded them recently, with a greater focus on school social work and youth coaches to prevent early school leaving. Two central trends are the gradual professionalisation of support and a stronger emphasis on case management to deliver more

targeted support. However, support is still too little and too general, caseloads are far too heavy, and the ratio of support staff to teacher is lower than in other OECD countries.

Second, Austria has an expanding array of support in place to help young people complete their education or apprenticeships and successfully transition into the labour market. Such help is critical because too many Austrians leave the education system early and young, low-skilled jobseekers struggle to find work. Measures rely heavily on the PES whose role is becoming even more important in the wake of recent benefit reforms. The PES is well placed and broadening its service provision, but its ability to help young Austrians who suffer from mental ill-health is still limited.

Shift education resources towards more professional support

- *Increase professional support in schools.* Although it has been expanded, there is less professional support in Austria than in other OECD countries. At the same time, the average class size and student-per-teacher ratio are comparatively low. More professional support staff is required in and for schools to help all children in need. That need could be met in coming years, without additional resources, by replacing some of the teachers due to retire in the coming decade with qualified support professionals rather than more teachers.
- *Continue the trend towards professionalisation*. Support staff needs professional training. The recent raising of the bar in qualification requirements for psychopedagogical training to university level with 120 ECTS credits should be continued and the annual number of teachers trained in this way increased. So, too, should qualification requirements for student advisers. Youth coaches also require specific training that enables them to play a greater role (see below).
- *Provide training and support for teachers*. Teachers have a key role in securing education outcomes for students with poor mental health. To live up to that role they need:
  - Knowledge of how to identify and handle mental health problems, which requires the teacher curriculum to be changed accordingly.
  - More support and supervision directed to them rather than to students in need. A certain share of psychopedagogues' counselling time could be set aside as teacher support time.

- *Integrate professionals more fully into the school environment.* Today, most professionals go into schools irregularly or when needs arise, waiting times for their services are often considerable, and they may be regarded as "outsiders" who are poorly integrated into school life. Improvements could be made, for example, by having permanent professional support staff in schools (as is now being done with the increase in numbers of school social workers). Schools should also include them in regular meetings and they should spend more time with teachers to give them greater support and discuss psychological and behavioural problems.

Provide case-managed, co-ordinated, multi-disciplinary support to curb early school leaving and ensure optimal education outcomes

- *Improve co-ordination and integrated support.* There is a range of pedagogical support services available to Austrian schools, all of which they need. While they generally follow a certain sequence in line with the student's needs, they are insufficiently integrated. It should be clear to students and teachers who to contact first. It should also be clear to support professionals what they are expected to do, and when. It would be useful to assign the task of co-ordinating intervention to a support professional who is permanently on site. Schools could choose whoever they deem most suitable, though youth coaches would be well placed to act as co-ordination hubs.

- *Make better use of available supports.* It has emerged that school psychologists and school doctors – a longstanding part of the Austrian system – do not work in an integrated enough manner with the newer professionals – psychopedagogues, social workers and youth coaches. As a result, valuable expertise and resources are being underutilised. School psychologists could spend more time with other professionals and in school and less on diagnostics. As for school doctors, they should be well trained in identifying and attending to mental health problems.

- *Expand Youth Coaching*. The Youth Coaching scheme yielded good results in its initial phase. If it is to be truly successful, it is critical that it reaches NEETs under age 19 even though they are no longer in school. To that end, youth coaches should collaborate more closely with youth welfare professionals, youth workers and the PES. Youth Coaching also requires

greater resources to ease coaches' average caseloads and provide the most intensive individual Step 3 support to all who need it, e.g. most NEETs.

- *Strengthen targeted case management.* The recent shift to a more intensive use of case management – a feature of youth coaches' work – should be continued. Social, behavioural and mental health problems are so multifaceted that blanket approaches will not help much. Moreover, it is important to address multidisciplinary problems with multidisciplinary solutions.

- *Strengthen links with the health system.* Mental illness is a great challenge to schools because it is under-diagnosed and under-treated. In Austria, as in other countries, under-treatment is high in general and particularly so among young people. A closer relationship between schools and the health system could make support more effective. Child psychiatrists could help schools to assess the needs of a student with mental illness, give support to school-based professionals, and provide treatment that takes particular school needs into account. That said, child psychiatry itself is underdeveloped in Austria and needs special attention to reduce the often long waiting lists for treatment for young people.

Promote and support robust labour market transitions

- *Help low-skilled youth improve their skills and find a job.* Despite the strong labour market, low-skilled youth in Austria face considerable barriers in finding a job. More efforts are required, especially from the PES, to help upskill such young people (through non-classroom training) and afford them a foothold in the labour market. In this regard, it should be made mandatory to notify the PES whenever students drop out of school or leave before completing their schooling.

- *Expand the Apprentice Coaching scheme with strong PES involvement.* Apprentice Coaching, still in its pilot phase, has demonstrated its potential for helping young people to complete vocational apprenticeships – plugging a gap that cannot be filled by Youth Coaching alone. Apprentice Coaching should be continued and made available throughout Austria with the strong involvement of the PES. Moreover, it should be available whenever apprentices risk not completing

their apprenticeships. There can be no case for any rigid eligibility criterion.

- *Move away from a focus on students with special education needs.* The focus of some existing measures on the (growing but still relatively small) group of students and jobseekers with special education needs is questionable. It robs most students with common mental disorders of support that could help them achieve their educational potential.

- *Make young social assistance benefit claimants a target group for the PES.* The relatively large number of young people claiming social assistance benefit is a group that includes many with mental disorders. The most recent benefit reform requires them more tightly to register with the PES, whose responsibility it is to activate them rigorously. The PES has to address all barriers to work, especially those that are health-related. Job-seeking exemptions should be granted very carefully and only for short periods. All exempted jobseekers should be seen by the PES caseworker frequently.

- *Develop mental health knowledge in the PES.* The PES' understanding of mental health in general needs to improve. With respect to young people, though, there is a particular pressing need. PES caseworkers need basic mental health training, while every public employment office should have professional psychological expertise.

- *Build stronger ties with schools, local authorities and the health system.* To make PES intervention more effective, PES offices should collaborate more closely with other authorities. Working with schools will enable earlier interventions, while working with local authorities and youth workers will help the PES to reach young NEETs. As for doctors, liaising with them will make it possible to address barriers related to mental ill health more effectively.

Notes

1. More details about this university-level training can be found under the link hwww.postgraduatecenter.at/lehrgaenge/bildung-soziales/integration-von-kindern-und-jugendlichen/ (accessed 1 June 2015).

2. There is a distinction in Austria between the three-year teacher training at teacher colleges for teachers in compulsory schools, and the four-year university training for high school teachers. Following many years of discussion, training will not be merged in the future but made more similar, by extending teacher-college training to four years.

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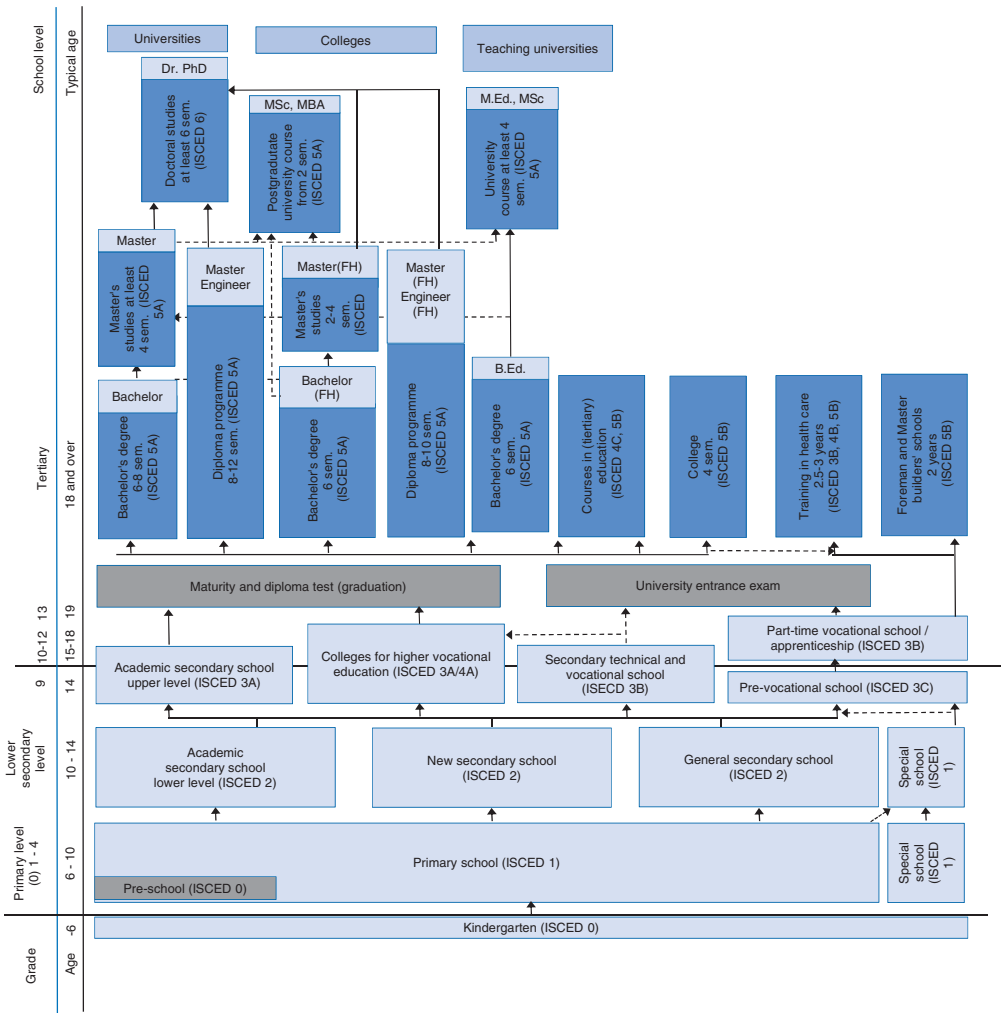
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ANNEX 4.A1

The structure of the Austrian education system

Figure 4.A1.1. **How the Austrian education system is organised**



Source: Federal Ministry for Education and Women's Affairs (Bundesministerium für Bildung und Frauen), www.bmbf.gv.at/enfr/school/bw_en/bw2013_e_grafik_17684.pdf?4du97u (accessed 1 June 2015).

Chapter 5

Linking mental health policy in Austria to other policy fields

Generally speaking, Austria has a differentiated, accessible health system. There are, however, capacity gaps in mental health care. Responsibilities, financing, and service provision are fragmented and centred on inpatient care, making the system costly and inefficient. There are significant regional differences in psychiatric treatment, with serious shortcomings in specialised services for children and adolescents. Mental health rehabilitation is widespread but mostly hospital-based. Despite considerable resources, waiting times for psychotherapy are long. And psychiatric treatment disregards work. This chapter discusses the main problems in Austrian mental health care and examines the system's potential for improving job retention and returns to work among people with mental health problems.

The statistical data for Israel are supplied by and under the responsibility of the relevant Israeli authorities. The use of such data by the OECD is without prejudice to the status of the Golan Heights, East Jerusalem and Israeli settlements in the West Bank under the terms of international law.

The mental health system plays a key role in increasing job retention and helping the unemployed with poor mental health into the workplace. Although most mental disorders cannot be cured definitively, it is possible to stabilise chronic, enduring symptoms through professional treatment, be it psychotherapy, medication, or a combination of the two. The provision of recommended treatment and making it a part of employment support is thus a precondition for tackling effectively the labour market exclusion of the mentally unwell.

Mental disorders require broad treatment concepts

While symptom reduction is desirable and necessary for enabling people with mental ill-health to work, it is not usually a sufficient condition. Even only very few symptoms may impair work, foster lingering uncertainty, compel the workplace to adjust, and require supervisors and working colleagues to be properly informed. Due to the combination of biological, psychological and social factors in the onset, manifestation, and course of virtually all mental disorders, effective psychiatric treatment has also to focus on the ability to function.

Most mental disorders have their first onset before young people make the transition from school or apprenticeship to employment. They are often enduring, with fluctuations between stabilisation and acute crisis, and most co-occur with other mental or physical health conditions. And the ability to work is affected – not only by symptoms, but by:

- a worker's personality, which can lead to troublesome conduct in the workplace
- the stigma that attaches to people who have an intangible health problem and may act unpredictably in the workplace.

The nature of mental ill-health thus requires a care system that has enough quantitative capacity and professional knowledge to treat those in need. Mental health services should be able to:

- Intervene early and sustainably.
- Offer care that integrates inpatient, outpatient, specialised and general treatment. The intensity of care should vary according to the fluctuating course of an illness.
- Combine psychiatric and physical treatment to address comorbidity.
- Intervene actively in difficult situations in the workplace in order to mediate between patients and employers.

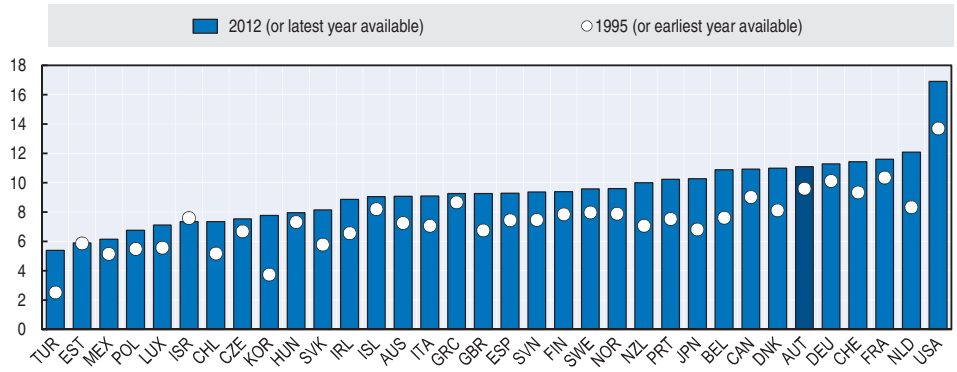
There is some evidence that mental health services in Austria do not score well on the four counts.

Health care is centred on inpatient treatment and physical illness

Austria has a broad, differentiated, health system with a high degree of equity in service access (OECD, 2011) that covers almost the entire population. However, health spending is relatively high – nearly 11% of GDP in 2012 and above the OECD average of around 10% (Figure 5.1).

Figure 5.1. **Health spending in Austria is among the highest in the OECD**

Health expenditure as a percentage of GDP, 2012 (or nearest year)



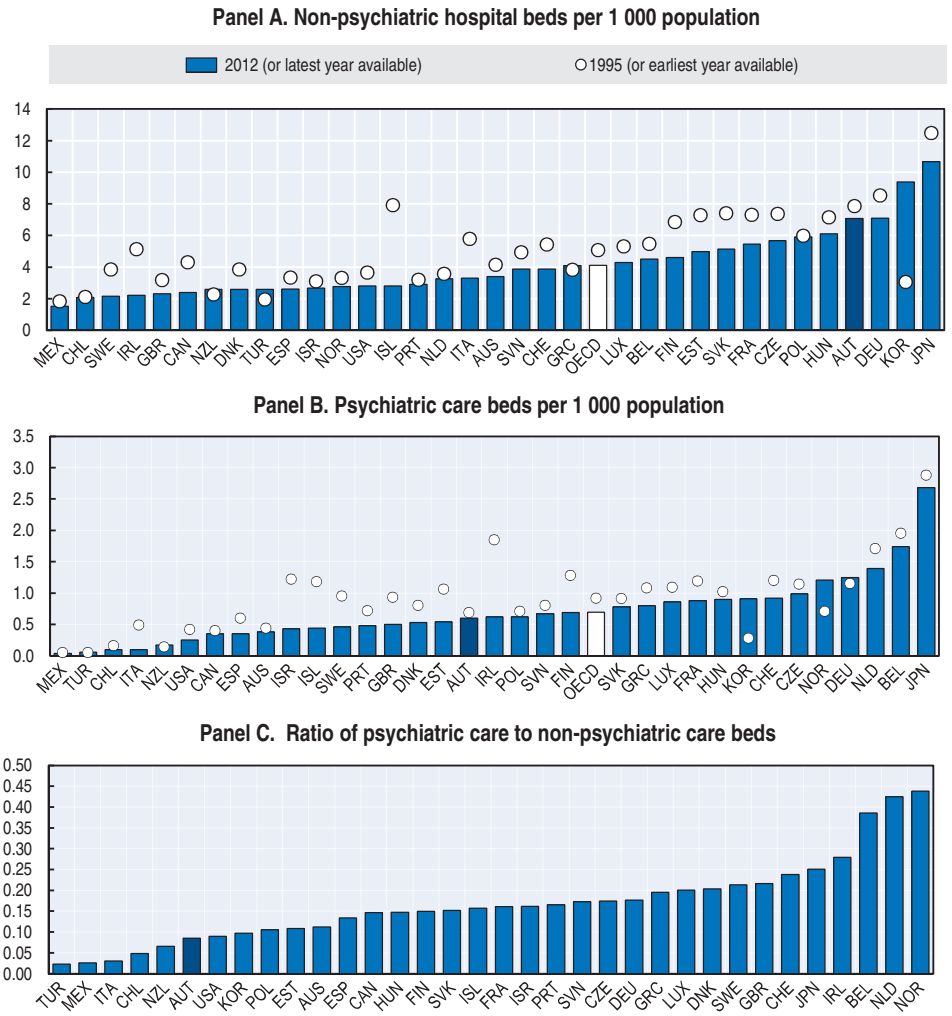
Source: OECD Health Statistics, www.oecd.org/health/healthdata (accessed 1 June 2015).

StatLink http://dx.doi.org/10.1787/888933239361

The high health expenditure is related to the large number of expensive inpatient beds in general hospitals: With around seven general hospital beds for every 1 000 people, Austria ranks fourth in the OECD (Figure 5.2, Panel A). Part of the reason is that hospital costs are funded largely by the federal government and, to a lesser extent, by sickness funds while they are administered by the regions. Neither sickness funds nor regions therefore have an incentive to replace inpatient care by outpatient services (OECD, 2011). Regional governments seek to maintain an extensive, locally accessible hospital infrastructure for electoral reasons.

Figure 5.2. **Health care is centred on hospital beds, with wide disparities between general and mental health care**

Psychiatric and non-psychiatric inpatient care by country, 1995-2012 (or nearest year)



Source: *OECD Health Statistics*, Health Care Resources, www.oecd.org/health/healthdata (accessed 1 June 2015).

StatLink http://dx.doi.org/10.1787/888933239378

To a lesser degree mental health care is inpatient-oriented, too

The strong focus on inpatient care is, to a lesser extent, also true when it comes to mental health. With around 0.6 psychiatric beds per 1 000 people, Austria is only just below the OECD average (Figure 5.2, Panel B). Including inpatient treatment for disorders related to substance abuse and psychiatric beds for children and young people in specialised facilities, there are around 4 800 psychiatric beds in Austria (Hofmarcher, 2013). There are also an additional 400 for adults and around 100 for young people with psychosomatic health problems, such as pain with no obvious physical cause. While those numbers are high in themselves, the ratio of mental to general health care beds shows that, in relative terms, very few resources go into mental health care (Panel C). With one psychiatric bed to 10 general health care beds, Austria's provision is lower than that of most of its OECD peers, pointing to a highly unequal distribution of health care resources and an underdeveloped awareness of the individual and economic burden of mental disorders in its medical health care community.

In 2009, mental disorders accounted for around 5% and 12% of all inpatient stays and days (Hauptverband, 2011). The distinction between stays and days stems from the relatively long periods of hospitalisation for mental disorders in Austria. Of all diseases, mental illness accounts for the second-longest inpatient stays after tuberculosis.

Many psychiatric patients are treated in general hospitals

A significant number of patients with mental health problems are not treated in psychiatric facilities. Around 30% of all inpatient treatment of people diagnosed with primarily psychiatric disorders (40% in the case of depression) takes place in general hospitals, mostly in internal medicine wards. The proportion rises to around 75% when mental conditions are a secondary diagnosis (Rittmansberger and Wancata, 2009). While it is plausible that many patients with substance abuse disorders, who often suffer from secondary physical problems, should be treated in general medical wards, it makes far less sense and appears much less effective for other mental illnesses such as those that are depression-related.

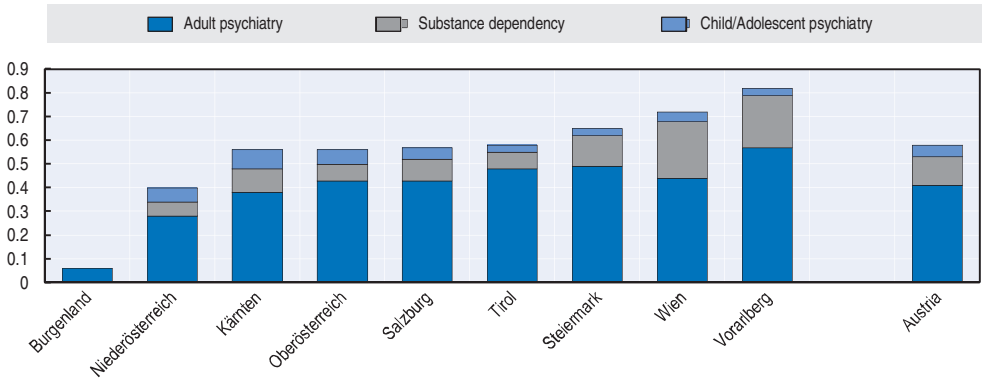
Despite the high number of psychiatric patients treated in general hospitals, the provision of specialised psychiatric wards has not increased sufficiently in recent decades. The lack of such wards is a missed opportunity, because they offer general hospitals an opportunity to tackle the frequent co-morbidity in patients with mental disorders. The inference must be that many psychiatric patients are still not sufficiently treated or referred to specialists (Katschnig et al., 2004).

Some regions have limited mental health care resources

Mental health care resources are not low only when compared to those for physical complaints, they also differ substantially from region to region. A recent analysis by the Austrian Association of Social Insurers (Hauptverband, 2011) reveals that regional variations in inpatient mental health care facilities are wide, with above-average resources in Vienna and Vorarlberg and less capacity in all other Austrian regions, especially Burgenland (Figure 5.3). Similar disparities are to be found in outpatient psychotherapeutic resources, with fewer resources in Upper Austria, Lower Austria, Carinthia and Burgenland. The scarcity of inpatient resources in some regions is not offset by an above-average provision in outpatient care (Eggerth et al., 2010).

Figure 5.3. **Regional differences are significant in inpatient resources for the main categories of mental health care**

Psychiatric beds per 1 000 population, by region, 2009



Note: Data in this analysis include only general adult psychiatry, not specialised psychiatric beds in, for example, forensic and old-age psychiatry. Numbers are, therefore, actually lower than those in OECD Health Statistics.

Source: Hauptverband der österreichischen Sozialversicherungsträger and GGK Salzburg (2011), "Analyse der Versorgung psychisch Erkrankter – Abschlussbericht".

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Specialised inpatient resources for children and adolescents are inadequate

Inpatient resources are particularly scarce in child and adolescent psychiatry. There are around 0.05 beds per 1 000 people – around one-tenth of the inpatient capacity for adult psychiatry (Figure 5.3). In 2009, there

were around 400 psychiatric beds for children and adolescents in Austria, which was significantly below the already low Austrian target level of between 0.08 and 0.13 beds for 1 000 people (Gesundheit Österreich, 2012).

An inadequate mental health care system for young people is problematic because early treatment increases the chances of recovery. Furthermore, child and adolescent psychiatry did not become an established medical specialty until 2009. Only in early 2015, the first outpatient psychiatric practices opened in Vienna, offering health insurance-financed treatment for children and adolescents. There are regions with no specialised child and adolescent psychiatrists – which explains why adolescents are generally treated in adult psychiatry and young children by paediatricians.

Outpatient treatment is scarce and uncoordinated

Generally, Austria has a very well developed outpatient health care system with 500 practising physicians per 100 000 people. The number is the second highest number in the OECD after Greece (600 physicians) and significantly higher than in any other OECD country where the range is between 200 and 400 doctors (Figure 5.4, Panel C).

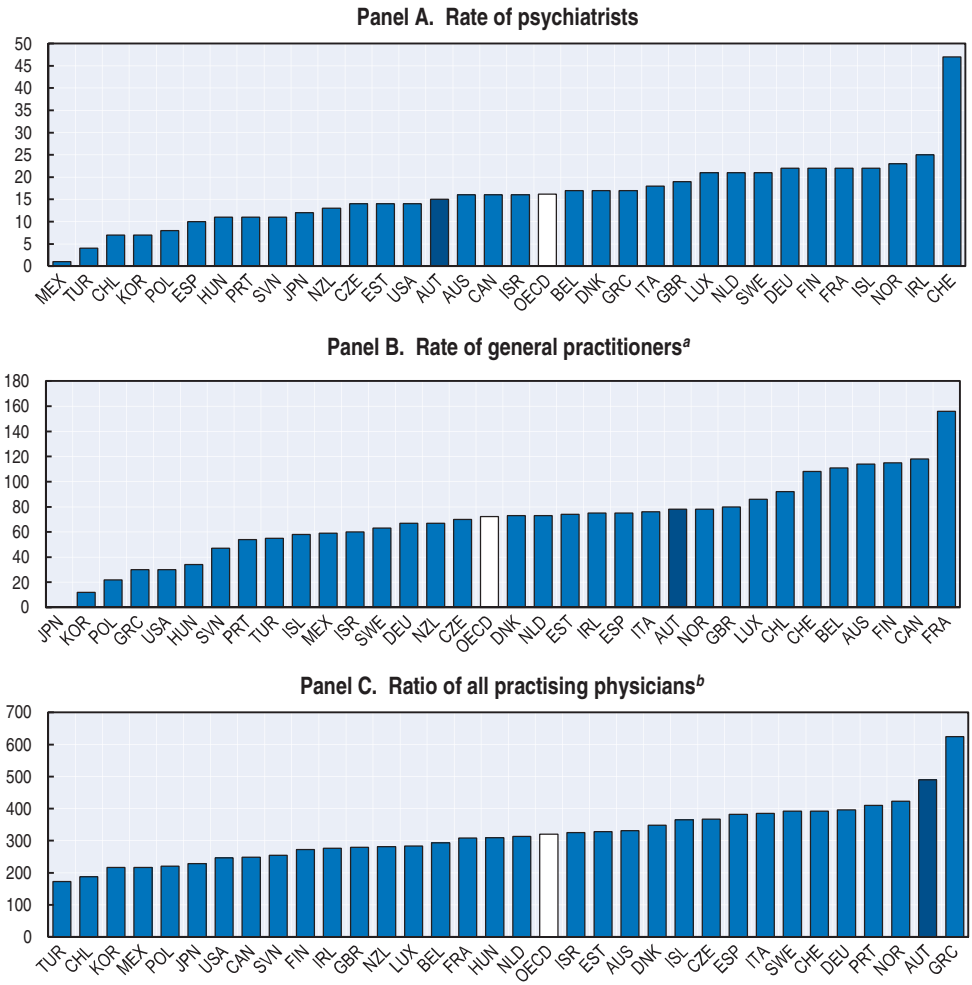
A very high rate of physicians, not of psychiatrists

When it comes to the density of general practitioners (GPs), Austria is slightly above the OECD average with around 80 per 100 000 people (Figure 5.4, Panel B). Yet despite those proportionately higher ratios, Austria is below the OECD average in density of psychiatrists (Figure 5.4, Panel A). The majority of Austrian physicians specialise in bodily ailments, which reflects the health care system's insufficient focus on mental ill-health. To compound matters, there are only very few outpatient, or mobile, psychiatric services.

The Association of Austrian Social Insurers estimates that, in 2009, around 900 000 people used the health care system for mental health reasons. Of those users, most were treated by a GP or psychotherapist (see below). Only around 200 000 – or 2.5% – received specialist care. Even then, many appointments with neurologists were for diagnostic purposes only, not for treatment. The "true" number of psychiatrically treated patients is around 120 000 (Hauptverband, 2011) – a prevalence of roughly 1.5% of the population and only half of the 3% estimated prevalence of severe mental disorders in the population (ibid). Those numbers point to a shortfall in specialised mental health care given the true prevalence of mental disorders in the population of between 25% and 30% (which includes mild-to-moderate conditions).

Figure 5.4. **Austria has the second highest ratio of practising physicians in the OECD, despite a lower-than-average number of psychiatrists**

Number of doctors per 100 000 people, latest year available



Note: The OECD average is an unweighted average.

a. Data for Denmark, Finland, Hungary and Switzerland refer to "generalist medical practitioners", a term that has a slightly broader sweep than "general practitioner".

b. Data for Greece, the Netherlands and Turkey refer to professionally active physicians. Chilean and Portuguese data refer to physicians licensed to practice.

Source: *OECD Health Statistics 2014*, Health Care Quality Indicators Data, www.oecd.org/health/healthdata (accessed 1 June 2015).

StatLink http://dx.doi.org/10.1787/888933239393

Accordingly, the density of psychiatrists in Austria is below the OECD average and significantly lower than in countries such as Germany or Switzerland. In Switzerland, which has an especially high density of psychiatrists (Figure 5.4, Panel A) for a comparable health care system and population size, around 330 000 people are treated annually by privately practicing psychiatrists (OECD, 2014).

Finally, the Austrian authorities estimate that around 20% of patients in psychiatrist practices do not meet the criteria of mental disorder. The inference is that under-treatment may be partly the result of treating the wrong people – something also observed in other countries.

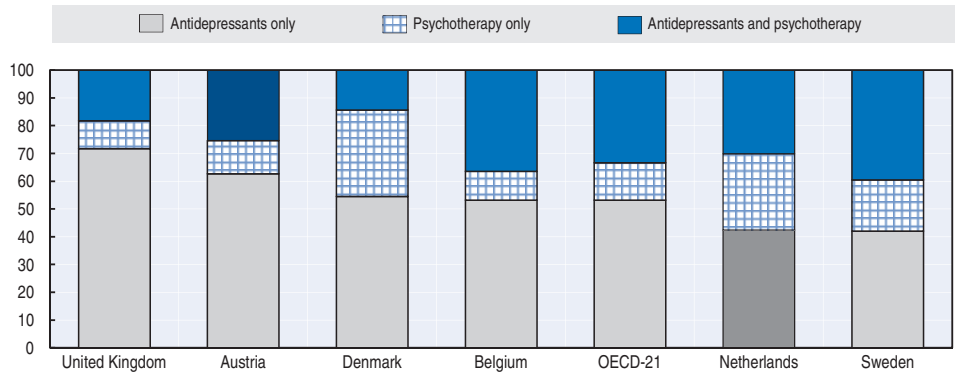
Psychiatrists rarely provide psychotherapy

Austrian psychiatrists provide treatment only seldom and, if they do, focus on diagnostics and medication. Individual or group psychotherapy accounted for only around 10% of the total costs of doctors in the field of psychiatry and neurology in 2008 (Hauptverband, 2011). And, despite the high number of psychologists and psychotherapists, psychiatrists and trained GPs generally provide psychotherapy – as much as 85% of it, according to an analysis of health insurance data in Austria and in the region of Burgenland (Eggerth et al., 2010).

Indeed, international comparisons reveal an under-provision of psychotherapy in Austria, where specialist treatment of mental ill-health often means psychoactive medication only (Figure 5.5). The use of psychotherapy, alone or combined with medication, is significantly below the OECD average. It should be noted that the Eurobarometer data in Figure 5.5 include treatment provided by psychologists and psychotherapists who do not prescribe drugs. If treatment by psychiatrists alone was considered, the rate of treatment that makes exclusive use of medication would be even higher.

Figure 5.5. **Austrians are heavy consumers of antidepressants**

Share of people in treatment[a] by type of treatment, 2005



Note: OECD-21 is an unweighted average.

a. Professional treatment for a psychological or emotional problem in the last 12 months.

Source: OECD calculations based on Eurobarometer, 2005.

StatLink http://dx.doi.org/10.1787/888933239408

Drug prescription patterns are worrying

Altogether, around 850 000 people with mental ill-health (not counting those who suffer from dementia) were prescribed medication in Austria in 2009 – around 10% of the population (Hauptverband, 2011). Almost half (47%) were antidepressants, as the number of people taking them rose by 16% between 2006 and 2009 nationwide. Over the same period, the number of patients being prescribed antipsychotic drugs increased by 10%, while those on tranquilisers remained stable.

As for working-age people, the proportion taking psychoactive medication is generally higher than among adolescents. Up to the age of 40, around 6% of all men and 9% of all women are on medication, while the rates are 10% and 18% respectively among the over-40s. The number of people prescribed psychoactive medication rose by 17% between 2006 and 2009, while all other prescription drugs increased by "only" around 6%. Accordingly, between 2006 and 2009 spending on psychoactive medication increased by 30%.

Prescriptions of antidepressants, antipsychotic medication and tranquilisers are much more widespread than specialist treatment. Psychiatrists and neurologists account for only around 10% of all prescriptions, compared to GPs at 70% and the 20% written by specialists in

physical illness (Hauptverband, 2011). Leaving 90% of all psychiatric medication to non-specialists is questionable given that few GPs are trained or experienced enough to prescribe psychoactive drugs with efficacy.

Low medication adherence

Of all patients receiving their first prescription in 2009, one-fifth had not been prescribed further medication three months later. As for antidepressants, more than 50% of patients stopped after three months at the latest, while the figure for antipsychotics was 46%. Around 10% of all prescriptions were single prescriptions that were never renewed.

There is little efficacy in one-off and short-term prescriptions, many of which are written by non-psychiatric doctors. Antidepressants in particular need several weeks to take effect, which reflects the often enduring nature of depressive and psychotic mental health conditions.

Evidence shows that psychiatric patient compliance with psychoactive prescriptions is low – as it is in other chronic health conditions. The result is high costs and low impact (WHO, 2003). Around 50% of patients with a mental disorder may fail to comply at any given point in the treatment. Beyond factors related to disorders and individual personalities, treatment-related factors are also important. There should be a good therapeutic relationship that affords patients an informed choice (Chakrabarti, 2014; Thompson and McCabe, 2012).

The potential of trained GPs is not fully used

Most people with a mental disorder are treated by their GP. However, in Austria as in many other countries, GPs often spot mental health problems without actively addressing them. There are a number of reasons:

- They do not have the time to talk with their patients in-depth and are not remunerated for such talking time.
- They lack the professional knowledge needed to intervene.
- They are not aware of the importance of referring patients with mental disorders to specialists.
- They cannot reach a psychiatrist who would be duly responsive.

Psychiatry has not been fully integrated into physicians' initial training. It is not a mandatory module, is very short, and does not include mental health rehabilitation. As a result, GPs are trained neither to consider patients, nor to work in multidisciplinary or shared-care settings, nor to collaborate with employers. Without such special training, GPs are not fully able to

identify and effectively treat patients with mental disorders, many of whom suffer from significant mental health-related problems in the workplace.

For physicians who want to practice psychosocial medicine, treat psychosomatic complaints, or offer psychotherapy, the Austrian Chamber of Physicians has created a system of further education – PSY-Diplomas at level 1, 2 and 3. PSY-3 qualifies GPs to provide psychotherapeutic treatment. There is some evidence that the system effectively improves GPs' psychiatric knowledge and awareness of the limits of their ability to provide treatment (Egger and Singer, 2007). Trained physicians seem to have better communication and intervention skills (Leitner et al., 2009; Langewitz et al., 2010) than non-trained GPs. Although there is still a lack in randomised controlled trials, the PSY-Diploma training seems to have a sustainable effect on daily clinical practice (Fazekas et al., 2009). Physicians who have not had "PSY" training, by contrast, overestimate their ability to care for patients with mental disorders.

GPs may experience a temporary loss of professional self-confidence when they first embark on their PSY-Diploma course. Qualifying, though, gives them a strong, renewed sense of professional identity at a higher level and enables them to specialise in psychiatry. In the past two decades, around 1 200 physicians have graduated at PSY-3 level and around 5 000 have passed at least one PSY-Diploma level.

Today, most psychotherapy is delivered by psychiatrists or physicians with a PSY-3 diploma. Treatment patterns differ widely between physicians and other psychotherapists. The average length of medicated psychotherapy face-time is 80 minutes per year, in contrast to typically 10-12 hours of psychotherapy treatment provided by psychotherapists in private practice or employed by a regional mental health organisation ("Versorgungsvereine") (Eggerth et al., 2010).

Most medical psychotherapy services seem to be single interventions that cannot be compared with true psychotherapy. GPs who often treat patients over long periods, could make a difference if they were to offer their patients more sustainably supportive psychotherapeutic interaction. Because many mental disorders are recurrent or long-lasting, patients need someone who takes charge and is approachable. Generally speaking, work problems that are related to mental health cannot be solved in one to three therapy sessions.

Funding and regulation of psychotherapy not always effective

Austria boasts an ample number of highly qualified specialists: around 2 200 psychiatrists and over 1 000 physicians with a PSY-Diploma 3. Added

to this there are also 6 000 psychotherapists with backgrounds in psychology and social work, and 7 000 clinical psychologists, whose job is screening, counselling and rehabilitation, but who are not allowed to provide treatment.

Psychotherapy-quota and refunding of costs are not sufficient

In no single Austrian region is basic mental health care fully secured (Eggerth et al., 2010). The main reason is that health insurance does not have a needs-based funding system, but an annual capped quota that is much low demand. So, for psychotherapy, the fixed amount of funding is usually used up long before the calendar year ends.

Social insurance partly or fully refunds the costs of psychotherapy in the following way:

- One or two psychotherapeutic associations in each region called "Versorgungsvereine" and psychosocial institutions – about 70 in Austria in total – which provide a range of services which include psychotherapy. The costs of their care are fully covered. However, both have limited capacity. Their costs amounted to 56% of all social insurance expenditure on psychotherapy in 2009.
- GPs with a PSY-3 Diploma or psychiatrists who offer psychotherapeutic treatment. They account for around 22% of all psychotherapy costs.
- Psychotherapists who work for social insurance bodies, though they account for only 1% of total costs.
- Psychotherapist practices, where social insurance pays a fixed subsidy towards the full costs of psychotherapy – EUR 22 for a 50-minute therapy session (unchanged since 1992). Patients have to co-pay for the rest, which is usually between two-thirds and three-quarters of the total cost. These social insurance subsidies amount to 21% of all psychotherapy costs (Eggerth et al., 2010; Hofmarcher and Quentin, 2013).

Although psychotherapy has been considered as medical treatment since 1992 and social insurance is required to cover the costs either in part or fully, the Association of Social Insurance Bodies and the Austrian Federal Association of Psychotherapy have not yet agreed on a general contract (Gesamtvertrag). More than 20 years later, psychotherapy continues to be a medical service which is, to a considerable degree, privately funded. To compensate for the lack of a general agreement, a puzzling variety of funding mechanisms has developed, shaped by the provider, the region and the regional health insurance.

Refunding criteria exclude the majority of people in need

The criteria for entitlement to co-funded psychotherapy vary from one regional health insurance to another. While the severity of a condition determines whether the cost of therapy is fully covered in one region, it may be the patient's economic situation in another, while a third region may consider both factors. To compound the complexity, there are many exceptions to the many rules. From an employment perspective, the existing priority criteria are not ideal, because they exclude the vast majority of people with mild-to-moderate mental health-related work problems and ordinary money worries. And all actors agree that more psychotherapeutic treatment places are needed, especially in rural regions where there are far fewer psychotherapists than in the regional capitals.

Social insurance expenditure on psychotherapy more than doubled from 2001 to 2009 (from 29 to EUR 63 billion) (Hauptverband, 2011). Fully funded psychotherapy was specifically prioritised, with expenditure increasing four-fold from EUR 10 to 40 billion. Spending on co-funded treatment, by contrast, remained very much at the same level (around EUR 20 billion). From a health care perspective, the greater focus on fully funded psychotherapy for severely mentally ill is understandable at first sight. However, such patients are often not those who benefit most from psychotherapy, as they require proper medication and psychosocial support. Prioritising fully funded therapy thus neglects once again the majority of the mentally unwell who suffer only from mild-to-moderate disorders. They would derive particular benefit from psychotherapy, as they are still at work and have a better prognosis, but might develop a more severe health condition if untreated.

Social insurance bodies are reluctant to increase levels of co-payment – unchanged since 1992 – because they fear that psychotherapists would merely increase the total cost of therapy, so increasing their own revenue without any real gain for the patients. It might therefore be better to increase the *number* of partially funded psychotherapy treatments rather than increasing only the *amount* of co-payment that social insurance provides. Such a solution might give greater incentive to more people to use psychotherapist treatment.

Waiting times for psychotherapy restrict the freedom of choice

People who suffer from mental ill-health face considerable waiting times for co-funded or fully funded therapy – between two and eight months, depending on the mental health care provider. Waiting time also depends on whether a patient is ready to be treated by any psychotherapist. While Austria grants the principle of freedom to choose a doctor, this

principle is restricted by capacity constraints. Another drawback is that information services are poorly organised and people in need may have to call a significant number of providers before finding a therapist. In short, barriers to treatment are high.

At the same time, however, the number of government-approved psychotherapeutic methods is very large. There are 22, ranging from psychoanalysis to behaviour-oriented, systemic techniques. Most are based on a psychodynamic, analytical approach which aims to afford patients insight into the workings of their experience and behaviour. The predominance of long-lasting, intensive, insight-oriented therapy creates problems, however.

First, many people cannot afford them. Second, many psychodynamic therapists explicitly refuse to intervene in their patients' real-world situation – they will not, for example, contact employers or mediate in workplace conflicts. Another disadvantage is that insight-oriented methods need time: they are not effective in the short run when work problems arise. Finally, many of the methods the Austrian Ministry of Health has approved are not evidence-based.

Altogether, the funding of psychotherapy is:

- *Complicated*. There are too many different regional solutions and a large number of different providers whom they pay at many different rates.
- *Ineffective*. Many qualified psychologists and psychotherapists could make a greater contribution to mental health care if subsidies for treatment costs were higher and clinical psychologists were allowed to provide treatment.
- *Not accurately* enough targeted on certain groups of patients.
- *Not evidence-based* and not seeking to help patients function more effectively in daily life.
- *Neglectful* of the large group of working people with mild-to-moderate mental health problems who need quick access to low-threshold psychotherapeutic treatment.
- *Underfunded*. Spending on psychotherapy is still low when compared to expenditure on inpatient care or medication-based treatment.

Poor integration minimises outcomes

In Austria, there is little collaboration between GPs and mental health care specialists. All providers – psychiatric clinics, outpatient facilities, psychiatrists, psychotherapists, psychosocial associations for mental health care, etc. – operate in silos. GPs have no defined pathways to systematic co-operation with different care providers or to shared case discussions (Eggerth et al., 2010; Meise et al., 2008). The main barrier to closer collaboration is the fragmented organisational and funding structure – e.g. inpatient care financed by the regions, outpatient care partly funded by the health insurance, and only around one-fifth of all privately practising psychiatrists having a contract with a health insurance body.

Austrian GPs have no gate-keeping role (OECD, 2011) and do not therefore steer health care provisions. According to an analysis in the Austrian Health Survey 2006-07 (Hoffmann et al., 2013), the number of people who see a GP annually is around 80% – a high figure that is comparable to European countries such as Norway, Ireland, or France. However, the figure is much higher than in other countries, at 67%, when it comes to the number of people seeking specialist outpatient care. This share is only 17% in Norway, for instance, where GPs are the gatekeepers of specialist health care. The high number of patients bypassing GP referrals not only makes the system costly, it also affects the integration and continuity of health care. The loss of information every time that a patient changes treatment provider further fragments care and impairs efficacy.

Widespread consultation of specialists in Austria does not help to avoid hospitalisation. Around 23% of the population goes to hospital as an inpatient at least once a year. Although access to treatment in Austria might seem very easy in general, it is fragmented. In other words, there is plenty of temporary in- and outpatient treatment, but very little of the sustained treatment planning required by recurrent or chronic mental health conditions. Moreover, patients with mental disorders mostly suffer from co-morbid conditions that call for a wide variety of support. Although there has been some discussion of the role of GPs in Austria over the past decade, they are not yet considered specialists in their own right and play no part in guiding patients through the health care system. Patients with long-term mental disorders would benefit greatly from GPs and psychiatrists being gate-keepers.

Communication between different providers and treatment planning are also hindered by low social insurance funding. Given the often multiple needs for care over extended periods in patients with mental disorders, easily accessed treatment that is not part of sustained, systematic collaboration is disconnected and, if effective, may be so only in the short

term. Health insurance funding regulations deter GPs from effectively and sustainably supporting recovery and social and occupational integration. They could improve treatment outcomes and be more cost-effective if health insurance gave the different health care providers greater incentive to collaborate and develop integrated treatment and rehabilitation plans.

No national strategy for mental health and work

One high-level way of enhancing service integration could be through a national plan for co-ordinating the services supplied by different sectors and providers. Austrian social insurance bodies have developed such a national strategy for mental health (Hauptverband, 2012). It addresses disease prevention, care and disability prevention, and considers a range of important problems such as shortcomings in integrated mental health care, in services for employees with mental health problems, and in the coverage of psychotherapy costs. The strategic aims are broad. They relate to mental health promotion and prevention, the stigma attaching to mental disorders, and evidence-based services. More specific targets include better co-ordinated planning of mental health care services, models of integrated care, a chain of care between inpatient and outpatient services and medical and psychosocial services, a stronger gate-keeping role for GPs and psychotherapy quality assurance. This national strategy now needs to bring those targets to life and take concrete action.

New health targets ("Rahmengesundheitsziele") published by the Federal Ministry of Health in 2012 make only a passing reference to the link between mental health and work with respect to "healthy working conditions" which are included among health-promoting living conditions. However, target No. 10 might offer a framework for further action, including early intervention in case of health-related problems. Similarly, the Federal Ministry's "National Strategy for Good Mental Health" lists ten main targets – e.g. the fostering of mental health, the prevention of mental illness, stigma, the funding of mental health care and vulnerable populations (like the children of mentally unwell parents). Yet it fails to mention the connection between mental health and work.

Psychiatric rehabilitation should be improved

The year 2002 saw the introduction of inpatient psychiatric rehabilitation centres, funded by disability insurance and – in the event of prolonged sickness absence – by health insurance bodies. They are designed to support people with mental disorders, improve their general ability to function day-to-day, and – in particular – to enable their re-integration into the workplace (Box 5.1).

Box 5.1. **Establishing psychiatric rehabilitation in Austria**

Psychiatric rehabilitation is relatively new in Austria. Medical rehabilitation, or convalescent medicine, was implemented much earlier in other medical fields, usually as an inpatient service – e.g. neurology or orthopaedics. Accordingly, mental health rehabilitation, too, was designed as an inpatient service (Haberfellner et al., 2008).

There are several target groups. One is patients who, after an acute crisis that required inpatient psychiatry, need further treatment to regain their functional capacity or to begin job rehabilitation. However, people on long term sickness absence, or otherwise at risk of labour market exclusion, are also ideal candidates for recover programmes (Schöny, 2008). Those with a substance-abuse problem or who suffer from acute psychosis, on the other hand, are not considered. Generally, patients should have a good rehabilitation prognosis.

Mental health rehabilitation programmes are limited to 4-8 weeks, though they may be extended and, within a five-year-period, repeated. To be eligible, patients should be stable enough to attend a programme of 20 therapy units per week (Haberfellner et al., 2008).

Psychiatric rehabilitation complements community-based psychosocial rehabilitation services (such as day centres, housing support, or sheltered work facilities) for people with severe and chronic mental health conditions. Patients in psychiatric rehabilitation are supposed to return to the labour market.

Psychiatric rehabilitation offers a broad range of treatment:

- individual and group psychotherapy
- relaxation methods
- medication
- occupational therapy
- creative therapies (art, music, dance)
- physical therapy
- health promotion
- "psycho-education" to learn how to manage the mental disorder
- discharge planning (organisation of outpatient treatment after discharge).

Psychiatric rehabilitation should take place in a therapeutic setting – an important requirement, as it gives patients a structure to their days, psychotherapy and labour market activation.

Source: Haberfellner, E. et al. (2008), "Medical Rehabilitation of Patients with Mental or Psychocomatic Disorders in Austria – Findings of a Catamnestic Study", *Rehabilitation*, No. 47, pp. 164-171; Schöny, W. (2008), "Zukunft der medizinischen Rehabilitation" [The future of medical rehabilitation], *Pro Mente Austria*, No. 4, pp. 7-8.

The outcomes of mental health rehabilitation in Austria are ambivalent (Haberfellner et al., 2008). Around two-third of all patients who were employed when they started rehabilitation were still employed one year after discharge from the programme (Figure 5.6, Panel A). And, in a promising

trend, of patients who were unemployed when they started rehabilitation, around 30% found work afterwards.

However, 55% of the initially unemployed were still unemployed or on disability benefit one year later, while those who started the programme as claimants of disability or other benefits had not changed status.

Employment status at the onset of rehabilitation thus appears a determining factor that has also been observed in other OECD countries. Mental health rehabilitation services should therefore seek to increase the number and share of patients still in employment: once people are looking at the prospect of disability benefit, rehabilitation comes too late.

Of all patients entering mental health recovery programmes 30% were employed one year after discharge (Figure 5.6, Panel B). Another 20% were unemployed and around 40% were on disability benefits or in the process of making a claim. One year after discharge from the programme, the situation looked worse. While around 30% of former patients were employed, the main change was that former unemployed and disability benefit applicants had become disability beneficiaries. The proportion of recipients actually rose from around 20% at the inception of the programme to over 40% one year after rehabilitation. Several contributory factors come into play.

- Waiting times for psychiatric rehabilitation are as long as one year (Schöny, 2008). And because early back-to-work interventions are so important, long waiting times – so often related to treatment gaps – may hinder successful job integration.
- Psychiatric rehabilitation services operate in a silo, disconnected from the workplace, unemployment services or mental health care. The provision of in-house occupational therapy cannot compensate the lack of co-operation with employers or job-placement support.
- Programmes primarily offer psychotherapy and other therapeutic services, and it is well established that treatment does not directly translate into employment outcomes. In that respect, psychiatric rehabilitation programmes are not easily distinguishable from inpatient treatment.
- Almost all rehabilitation programmes are inpatient services (with the exception of one outpatient programme in Vienna implemented in 2010). There is a disconnection with patients' places of work and abode. More outpatient rehabilitation facilities that allow patients to work part-time would help to improve outcomes.

Figure 5.6. **Psychiatric rehabilitation brings little net change in employment status**



Source: OECD calculations based on data provided by Haberfellner, E. et al., (2008), "Medical Rehabilitation of Patients with Mental or Psychosomatic Disorders in Austria – Findings of a Catamnestic Study", *Rehabilitation*, Vol. 47, pp. 164-171.

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The recent mental health strategy concluded that inpatient and outpatient psychiatric rehabilitation services should be expanded (Hauptverband, 2012). Such expansion of psychiatric rehabilitation should come with some critical changes in concept. It should be designed as easy, quickly accessible programmes for people still in work. And it should provide outpatient workplace-based support, target specific individual work problems and aim primarily at job retention.

Round-up and recommendations

In order to support job retention and resumption, a mental health care system has to provide a sufficient inpatient and outpatient treatment provision. And it needs to be responsive to the special nature of mental disorders: their early onset, their frequently long duration and co-morbidity, sufferers' lack of insight into their condition, and the stigma that attaches to mental ill-health in the workplace. Treatment should therefore:

- start early
- be co-ordinated between the different care providers
- offer integrated support to physical and mental health complaints, with a long-term perspective
- provide real-life support to both young people in school and apprenticeships and to adult patients in the workplace.

While Austria has a differentiated, inclusive and easily accessible health system that is appreciated by the population, mental health care lags behind the treatment of physical ailments. Its structures also found wanting, with no health care professionals to steer the mentally ill towards the right port of call, inadequate funding and treatment practices that are poorly targeted and disregard the workplace.

Significant shifts in resources are required

- *Shift resources from specialised physical medicine to mental health care.* Austria has an inpatient-oriented health care system with a very high proportion of specialists in illnesses of the body that is way above the OECD average. Expenditure on health care is among the highest in the OECD. However, the share of psychiatrists is below the OECD average, child and adolescent psychiatry is inadequate, and psychiatric wards in general hospitals are scarce. The federal authorities, together with health insurance bodies and the regions, should seek to steer the allocation of resources towards a more even balance.
- *Shift resources from inpatient to outpatient mental health care.* Health care is still generally inpatient-oriented, while access to outpatient mental health care is dictated by frequently lengthy waiting times and/or the restricted freedom to choose a doctor. Resources should be diverted towards outpatient treatment instead of hospital beds and be combined with an approach that uses work-related targets and quality indicators.

- *Shift significant resources to child and adolescent psychiatry.* There is a dearth of child and adolescent psychiatrists in Austria, partly because it is a relatively new medical speciality. Although the shortage is widely acknowledged, efforts to increasing the number of such psychiatrists should aim higher than they currently do. Because their health and education are at stake, it is essential to intervene early in mental disorders that affect young people. Accordingly, child and adolescent psychiatry should be made part of medical training and incentives to develop private practices and outpatient care should be introduced.

- *Shift resources from diagnostics to treatment.* Although there is a shortage of psychiatric and psychotherapeutic treatment, diagnostic activities are widespread. There are many well-qualified psychologists concerned chiefly with diagnostics who are not allowed to provide treatment. Almost half of all consultations with patients suffering from poor mental health yield diagnoses only, not treatment. In view of the current under-treatment, funding should support treatment rather than diagnostics and evaluation.

- *Shift resources from regional capitals to rural areas.* Vienna and other regional capitals enjoy ample resources in mental health care. In Vienna, for example, GPs with a PSY-3 Diploma are not recognised psychotherapists, because the number of psychiatrists is considered so high that a training of general physicians is not considered necessary. Rural regions, by contrast, suffer from a shortage of specialised structures. Accordingly, there should be incentives for mental health care professionals to practice in rural regions – in partnership with paediatricians or GPs, for example.

Change medication practices

- *Train GPs in talking therapies and compensate them adequately.* In Austria, the share of the mentally ill who are treated solely with psychoactive medication is relatively high and significantly above the OECD average. However, in many mental health conditions, a combination of medication and psychotherapy yields the best results. Because GPs usually use medication to treat mental illness, they should be encouraged to offer interpersonal therapy, too. Their training should always include psychological treatment and they should be better compensated for the significant length of time they spend talking with their patients.

- *Train GPs in the use of psychotropic medication and restrict prescriptions by specialists who are not mental health care professionals.* GPs are the biggest prescribers of psychotropic drugs,

while physical illness specialists account for 20% and mental health specialists like psychiatrists and neurologists only 10%. GPs need to be better trained in the use of recommended medication and should contact psychiatrists at an early stage in complicated, long-lasting mental illness. Psychoactive drug prescription by specialists who are not mental health professionals could be made conditional on, for example, collaboration with or referrals to specialised mental health doctors. Finally, medication patterns could be routinely reviewed by pharmacists who would then feed their findings back to prescribing physicians.

- *Strengthen medication compliance with follow-up procedures.* While the prescription of medication is highly prevalent, efficacy is limited by low compliance. To improve adherence, procedures should be developed to enable GPs to follow up on prescriptions. They should include advice on when to contact specialists.

Empower GPs for assuming a bigger role

- *Train GPs in identifying and treating mental health problems.* Most people with a mental health problem are seen by GPs. However, GPs seldom – if at all – address the problems properly. Mental disorders should be made a higher priority in physicians' initial and further training.
- *Train GPs in how to address mental health-related work problems and pay them for interventions in the workplace.* Most supervisors are ill-equipped for dealing with employees who suffer from mental health conditions. To plug that gap and prevent long-term absences, GPs should be trained to spot their patients' work-related problems early and intervene in the workplace – e.g. by advising supervisors on how to deal with mentally unwell employees and adjust the workplace. Health insurance should pay doctors for their workplace-oriented action.
- *Improve collaboration between GPs and specialists.* While mental health care in Austria is often episodic and isolated, GPs usually have long-term relationships with their patients – a good base for offering sustainable support to those with mental ill-health and guiding them through the specialised mental health care system. The effectiveness of GP treatment would be increased by a clear strategy of referrals to and collaboration with mental health specialists. Health insurance could facilitate shared-care models in order to strengthen links between GPs and specialists.

Change the funding of psychotherapy

- *Widen funding for psychotherapy.* There should be a wholesale rise in funding for psychotherapy. It should apply not only to fully-funded psychotherapies that are bound to certain criteria. To improve access to psychotherapy, the number of therapies that are partially funded and the level of that funding should also be increased.

- *Reconsider psychotherapy funding criteria.* Current psychotherapy funding criteria focus on the severity of conditions. However, psychotherapy is not always recommended when it comes to serious mental disorders, while it may be highly effective in people with moderate disorders. The majority of people affected by mental ill-health suffer from mild-to-moderate conditions and are in work. To reach this group, mental health problems that are related to working conditions could be given pride of place in criteria for psychotherapy funding.

- *Implement tools for monitoring how patients function.* In order to better assess both the need for and possible benefits of psychotherapy, health insurance could require not only that diagnoses be registered, but also that patients' ability to function in society and the workplace should be assessed with tools like the General Assessment of Functioning (GAF). Such monitoring instruments could help health insurance target therapy funding more effectively.

- *Restrict the number of recognised therapies.* The Health Ministry recognises 22 different psychotherapeutic methods. Many have an insight-oriented, psychodynamic framework with a long-term outlook that sometimes explicitly rules out any therapy that addresses how patients function in the real world day-to-day. Few of the approved therapy methods have a sound evidence base. The Health Ministry should – together with the Federal Association of Psychotherapy – restrict the therapies it approves to a reasonable number with documented effectiveness.

- *Develop work-oriented criteria for psychotherapists.* In order to strengthen the workplace focus in psychotherapy, psychotherapists' obligatory full training in an approved psychotherapy method should be expanded to include special knowledge and experience of, for example, interventions in workplace-based problem situations or successfully supporting returns to work. Therapists who meet such additional criteria could be financially rewarded.

Improve the employment focus of mental health care

- *Bring the national strategy on mental health to life.* The Austrian Association of Social Insurers has developed important strategic targets for better co-ordinated navigation of mental health care, integrated care, effective psychotherapy and the role of GPs. The insurers should now implement and evaluate their strategy through action plans and concrete measures that incorporate not only voluntary co-operation activities but funding mechanisms and financial incentives, too. Routine data should be collected and monitoring tools implemented in various areas to establish an evidence base for the direction of effective mental health care. Finally, concrete action should also give priority to building a link between treatment and employment.

- *Improve psychiatric rehabilitation.* Psychiatric rehabilitation was established only around a decade ago to treat inpatients. While rehabilitation programmes may benefit some patients' employment outcomes, their multidisciplinary potential is still underused for the vast majority of people with mental ill-health who are still in work and have good recovery prognoses. Psychiatric rehabilitation should be re-designed to include outpatients, be quickly accessible to both employees and supervisors, and allow early intervention in workplace problems or conflicts related to mental ill-health in order to strengthen job retention. Generally speaking, psychiatric rehabilitation should widen its focus to the moderately ill.

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