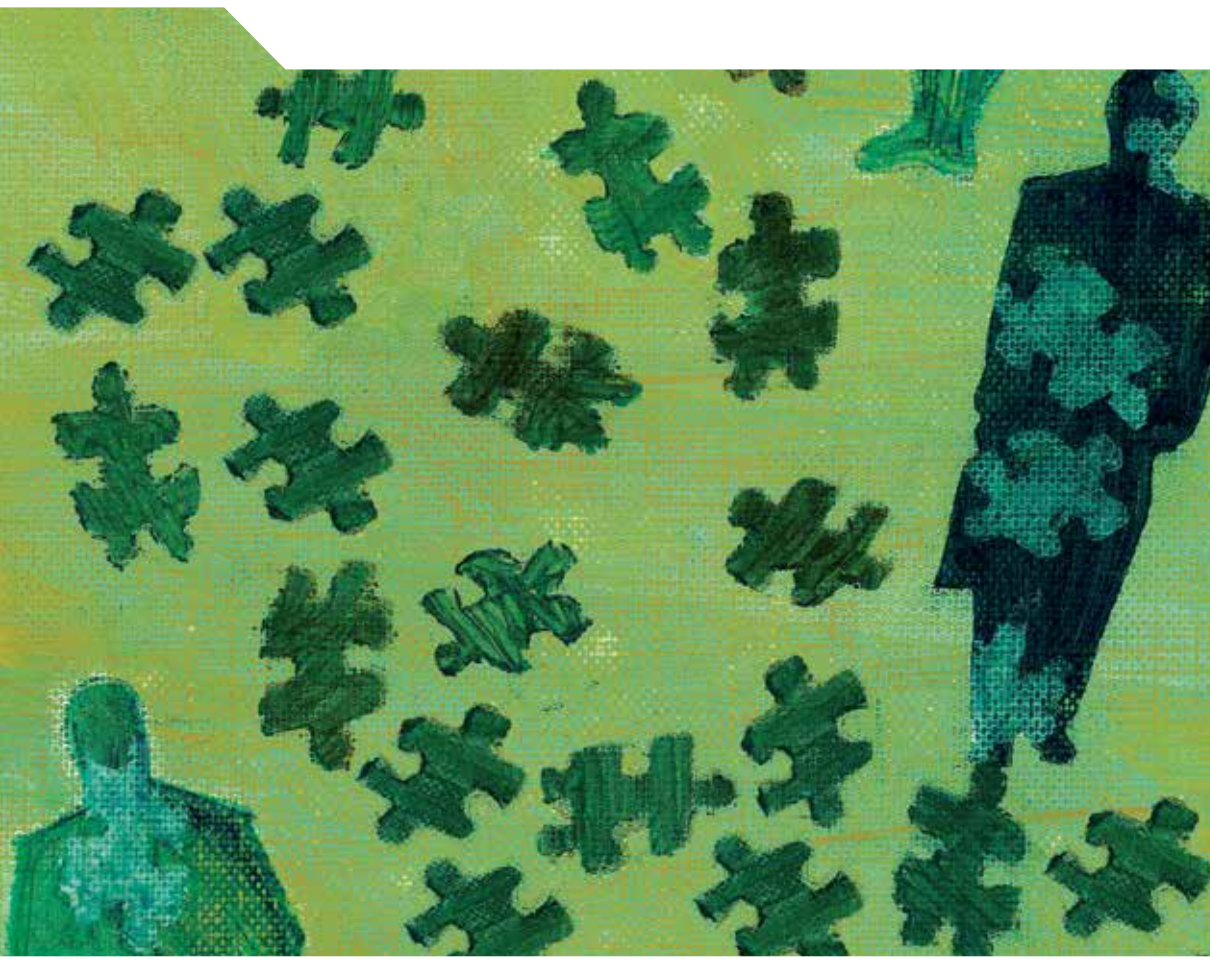
Mental Health and Work

NETHERLANDS



OECD

Mental Health and Work: Netherlands



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Foreword

Tackling mental ill-health of the working-age population is becoming a key issue for labour market and social policies in many OECD countries. It is an issue that has been neglected for too long despite creating very high and increasing costs to people and society at large. OECD governments increasingly recognise that policy has a major role to play in improving the employment opportunities for people with mental ill-health, including very young people especially; in helping those employed but struggling in their jobs; and in avoiding long-term sickness and disability caused by a 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 the main underlying policy challenges facing OECD countries by broadening the evidence base and questioning some myths around the links between mental ill-health and work. This report on the Netherlands is one in a series of reports looking at how these policy challenges are being tackled in selected OECD countries, covering issues such as the transition from education to employment, the role of the workplace, the institutions providing employment services for jobseekers, the transition into permanent disability and the capacity of the health system. The other reports look at the situation in Australia, Austria, Belgium, Denmark, Norway, Sweden, Switzerland and the United Kingdom. Together, these nine reports aim to deepen the evidence on good mental health and work policy. Each report also contains a series of detailed country-specific policy recommendations.

Work on this review was a collaborative effort carried out jointly by the Employment Analysis and Policy Division and the Social Policy Division of the OECD Directorate for Employment, Labour and Social Affairs. The report was prepared by Iris Arends and Veerle Miranda under the supervision of Christopher Prinz. Statistical work was provided by Dana Blumin. Valuable comments were given by Robin Risselada and Shruti Singh. The report also includes comments from various Dutch experts, ministries and organisations, including the Ministry of Social Affairs and Employment; the Ministry of Education, Culture and Science; the Ministry of Health, Welfare and Sport; the Employee Insurance Agency (UWV); and the Dutch Association of Mental Health and Addiction Care (GGZ).

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Acronyms and abbreviations

AWBZ	Exceptional Medical Expenses Act
DSM	Diagnostic and Statistical Manual of Mental Disorders
ESA	Employment and Support Allowance
ESENER	European Survey of Enterprises on New and Emerging Risks
ESL	Early School Leavers
EU	European Union
EUR	Euro
EWCS	European Working Conditions Survey
FACT	Flexible Assertive Communication Treatment
GDP	Gross Domestic Product
GGZ	Dutch Association of Mental Health and Addiction Care
GP	General Practitioner
FTE	Full-time equivalent
HAVO	Higher general education
HBO	Higher vocational education
IAPT	Improving Access to Psychological Therapies
IB	Invalidity Benefit
ICD	International Classification of Diseases
Inspectie SZW	Inspection of Social Affairs and Employment *(Inspectie van Sociale Zaken en Werkgelegenheid)*
IPS	Individual Placement and Support
IVA	Income Scheme for Fully Disabled Persons
LINH	National Information Network Primary Care *(Landelijk Informatie Netwerk Huisartsenzorg)*

MBO	Vocational education
NEWS	Netherlands Employers Work Survey
NVAB	Netherlands Society of Occupational Medicine
NZa	Dutch Health Authority (*Nederlandse Zorgautoriteit*)
OP	Occupational Physician
POH-GGZ	Supporting Counsellor Mental Health Care (*Praktijkondersteunend hulpverlener geestelijke gezondheidszorg*)
RMC	Regional Register Centres
SCP	Institute for Social Research
SME	Small and Medium-Sized Enterprise
SZW	Ministry of Social Affairs and Employment (*Ministerie van Sociale Zaken en Werkgelegenheid*)
UWV	Employee Insurance Agency
VMBO	Intermediate pre-vocational education
VWO	Scientific preparatory education
Wajong	Disablement Assistance Act for Handicapped Young Persons (*Wet werk en arbeidsondersteuning jonggehandicapten*)
WAO	Law on Invalidity Insurance
Wet LIZ	Act on Long-term Intensive Care
WGA	Return to Work Benefits for partially disabled persons
WIA	Work and Income Act
WMO	Act for Social Support
WO	Academic higher education
Wwb	Law on Work and Assistance (*Wet Werk en Bijstand*)
Wsw	Law on Social Work Provision (*Wet sociale werkvoorziening*)
ZAT	Regional care and advice teams *(Zorg en Advies Teams*)
Zvw	Health Insurance Act

Executive summary

Throughout the OECD, mental ill-health is increasingly recognised as a problem for social and labour market policy; a problem that is creating significant costs for people, employers and the economy at large by lowering employment, raising unemployment and generating productivity losses.

Over the past two decades, the Dutch Government has strengthened obligations and incentives for individuals and employers to co-operate in return-to-work management. These investments have successfully improved labour market outcomes for people with health problems. Sickness absences and disability benefit claims have fallen overall but absences remain high for people with mental ill-health and and the share of mental disorders in disability claims is increasing.

Important challenges persist in the area of mental health and work, including the lack of attention for people with mild-to-moderate mental disorders (such as psychological distress, depression or anxiety) in all sectors; little attention on the prevention of mental ill-health at work; limited public support to help sick people return to work; and the lack of co-ordinated and integrated (mental) health and employment support.

To improve sustainable labour market inclusion of people with mental illness the OECD recommends that the Netherlands:

- Provide direction to schools to: i) support pupils with mild-to-moderate mental health problems; ii) implement preventive activities; and iii) improve the transition from school to work for adolescents with mental health problems.

- Implement and monitor employer obligations to prevent mental ill-health at work and ensure sufficient support for employees by providing training to return-to-work case managers and occupational physicians in mental health issues.

- Improve the activation approach of the Employee Insurance Agency to better support their clients with mental ill-health in re-entering the labour market.

- Make sure municipalities have the appropriate means and multidisciplinary knowledge to activate clients with severe labour market disadvantage, especially including people with mental ill-health.

- Develop employment-oriented mental health care and experiment with ways to integrate health and employment services.

Assessment and recommendations

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

The Netherlands has a dynamic, evidence-based reform climate

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Summary of the main OECD recommendations for the Netherlands

Key policy challenges	Policy recommendations
1. School services are under-resourced and insufficiently focus on prevention and moderate mental health problems.	• Ensure full coverage of internal and external care teams for all education levels. • Implement preventive programmes in schools focusing on coping skills, emotional learning and resilience. • Install job coaches in secondary, vocational and higher education to support youths with mild-to-moderate problems in their transition into the labour market. • Improve the competence of teachers to identify and deal with mental health problems.
2. The well-developed occupational health system is not used in an optimal way.	• Ensure better labour law compliance related to psychosocial risk prevention. • Provide workers with the opportunity for preventive consultations with their occupational health services. • Create a professional profile for the return-to-work case manager, which should include knowledge on the interaction between work and mental health.
3. Activation policy by UWV for people with mental ill-health is insufficient.	• Develop measures to identify jobseekers with psychosocial problems even before they fall sick and offer appropriate support in co-operation with the health sector. • Oblige early intervention by UWV through the development of a work plan within eight weeks of sickness absence regardless of health status and work capacity. • Improve sickness and disability management through job coaching, active recruitment into jobs and co-operation with the mental health sector. • Introduce financial incentives for UWV to improve their activation policy.

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

Key policy challenges	Policy recommendations
4. Municipalities are confronted with an increase in caseload combined with a significant decrease in budgets.	• Monitor municipal efforts by benchmarking outcomes in a transparent database. • Encourage sharing of best practices between municipalities, in particular regarding integrated support across sectors. • Scale up municipal resources if necessary as savings at the municipal level might affect other systems, such as the disability system and the mental health care sector.
5. The mental health care system does not incorporate employment in the treatment process.	• Include indicators on employment outcomes in the mental health care quality framework. • Incorporate workplace knowledge in GP practices either by training the assistant mental health care specialist (i.e. the POH-GGZ) or by providing funding for an employment specialist. • Improve collaboration and mutual referrals between OPs and treating doctors through a better use of the existing guidelines for each profession.

Chapter 1

Mental health and work challenges in the Netherlands

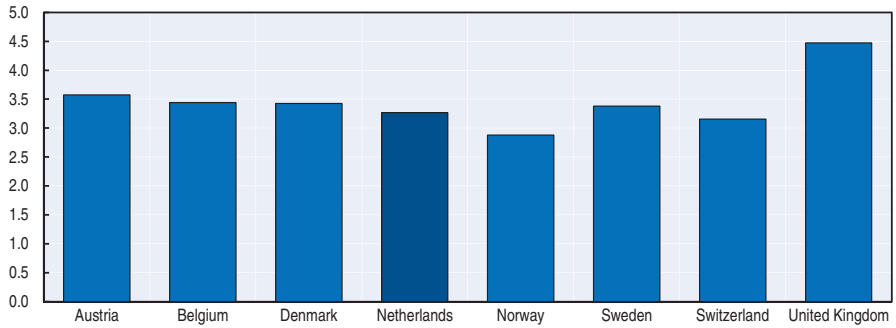
Building on the findings of the OECD report "Sick on the Job?" *this chapter highlights the key challenges that the Netherlands face in the area of mental health and work. It provides an overview of the labour market performance of people with a mental disorder in the Netherlands compared with other OECD countries as well as their dependence on different income replacement benefits. The chapter ends with a discussion of the upcoming policy reforms in the social field which will further devolve government responsibilities to the individual, employers and municipalities.*

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 poses important challenges for the smooth functioning of labour markets and social policies in the Netherlands as much as in other OECD countries. These challenges have not been addressed adequately so far, reflecting widespread stigma and taboos as well as a lack of evidence about the extent of the problem and the policy responses that are required. The total estimated costs of mental ill-health for society are large, reaching 3-4.5% of GDP across a range of selected OECD countries and 3.3% in the Netherlands (Figure 1.1).[1] Indirect costs in the form of lost employment and reduced performance and productivity are much higher than the direct health care costs. Based on comprehensive cost estimates by Gustavsson et al. (2011), indirect costs, direct medical costs and direct non-medical costs amount to 53%, 36% and 11%, respectively, of the total costs of mental disorders for society.[2] The high cost of mental illness is a direct consequence of its high prevalence in the population.

Figure 1.1. **Mental disorders are very costly for society**

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



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

Source: OECD compilation based on Gustavsson, A., M. Svensson, F. Jacobi et al. (2011), "Cost of Disorders of the Brain in Europe 2010", *European Neuropsychopharmacology*, Vol. 21, pp. 718-779 for cost estimates, and Eurostat for GDP.

StatLink http://dx.doi.org/10.1787/888933145358

Definitions and objectives

Notwithstanding the evident major costs of poor mental health in many OECD countries, policies and institutions are not addressing mental ill-health sufficiently. As discussed in the OECD report *Sick on the Job? Myths and Realities about Mental Health and Work* (OECD, 2012), being aware of the high prevalence of mostly mild-to-moderate mental illness and understanding the characteristics of mental ill-health is critical for devising the right policies.

Mental disorder in this report is defined as mental illness reaching the clinical threshold of a diagnosis according to psychiatric classification systems like the International Classification of Diseases (ICD-10) which is in use since the mid-1990s (ICD-11 is currently in preparation). Thus defined, at any one moment some 20% of the working-age population in the average OECD country is suffering from a mental disorder, in most cases a mood or anxiety disorder, with lifetime prevalence reaching up to 40-50%. For the purpose of this report, survey data is used to assess the characteristics and labour market outcomes for this group in the Netherlands (see Box 1.1).

The key attributes of a mental disorder are: an early age at onset; its persistence and chronicity; a high rate of recurrence; and a frequent co-existence with physical or other mental illnesses. The more severe, persistent and co-morbid the illness, the greater is the degree of disability associated with the mental disorder and the potential impact on a person's work capacity.[3]

Box 1.1. **The measurement of mental disorders**

Administrative clinical data and data on disability benefit recipients generally include a classification code on the diagnosis of a patient or benefit recipient, based on ICD-10 (International Classification of Diseases, version 10), and hence the existence of a mental disorder can be identified. This is also the case in the Netherlands. However, administrative data do not include detailed information on an individual's social and economic status and they only cover a fraction of all people with a mental disorder.

Survey data can provide a rich source of information on socio-economic variables, but in most cases only include *subjective* information on the mental health status of the surveyed population. Nevertheless, the existence of a mental disorder can be measured in such surveys through a mental health instrument, which consists of a set of questions on aspects such as irritability, nervousness, sleeplessness, hopelessness, happiness, worthlessness, and the like, with higher values indicating poorer mental health. For the purposes of the OECD reviews on *Mental Health and Work*, drawing on consistent findings from epidemiological research across OECD countries, the 20% of the population with the highest values according to the instrument used in each country's survey is classified as having a mental disorder in a clinical sense, with those 5% with the highest value categorised as "severe" and the remaining 15% as "mild and moderate" or "common" mental disorder.

This methodology allows comparisons across different mental health instruments used in different surveys and countries. See OECD (2012) and www.oecd.org/els/disability for a more detailed description and justification of this approach and its possible implications. Importantly, the aim here is to measure the social and labour market outcomes of people with a mental disorder, not the prevalence of mental disorders as such.

Box 1.1. **The measurement of mental disorders** *(cont.)*

For the Netherlands, data from three different surveys are used in this report: i) The *Dutch POLS Health Survey* of 2001-03 and 2007-09: the mental-disorder variable is based on the 5-item Mental Health Inventory (MHI-5), a scale with five questions aimed at identifying the absence of psychological distress; the items relate to depression and anxiety mainly; ii) The *Eurobarometer* for 2005 and 2010: the mental disorder variable is based on a set of nine items: feeling full of life, feeling tense, feeling down, feeling calm and peaceful, having lots of energy, feeling downhearted and depressed, feeling worn out, feeling happy, feeling tired; iii) The *European Working Conditions Survey* (EWCS) for 2010: the mental disorder variable is based on a set of five items: feeling cheerful, feeling calm, feeling active, waking up fresh and rested, having a fulfilling life.

One important general challenge for policy makers is the high rate of non-awareness, non-disclosure and non-identification of mental disorders – directly linked with the stigma attached to mental illness but also the very essence of mental cognition because people consider what they experience as normal. However, it is not clear in all cases whether more and earlier identification would always improve outcomes or, instead, may contribute to labelling and the risk of stigmatisation. This implies that reaching out to people with a mental disorder is more important than labelling them and policies that avoid labelling might sometimes work best.

The OECD report *Sick on the Job?* (OECD, 2012) puts forward two key directions for reform. First, policies should move towards preventing problems, identifying needs and intervening at various stages of the lifecycle: including at school, during the school-to-work transition, at the workplace, and when people lose their job or move into the benefit system. Second, steps should be taken towards a coherent approach across different sectors, integrating health, employment and, where necessary, other social services. Four core priority areas were identified which needed urgent policy attention. These include:

- *Schools* to protect and promote the mental health of children and young people and *transition services* to help vulnerable youth access the labour market successfully.
- *Workplaces* to protect and promote mental health of workers in order to prevent illness, reduced productivity at work and, ultimately, labour market exit.
- *Employment services* for beneficiaries of long-term sickness, disability and unemployment benefits who are outside of the labour force.
- *Mental health services* delivered in ways that assist people of working age to either remain in work or return to work.

This report examines how policies and institutions in the Netherlands are addressing the challenge of ensuring that (mostly mild-to-moderate) mental ill-health does not mean exclusion from employment and that work contributes to better mental health. The structure of this report is as follows. The remainder of this chapter sets the scene by looking at some of the key labour market and social outcomes for people with a mental disorder in the Netherlands in comparison with other OECD countries and giving a short overview of the upcoming reforms. Chapters 2 to 5 consecutively analyse the policy challenges the Netherlands face in the education system, the workplace, the benefit systems and the health system.

Key trends and outcomes

Labour market outcomes

People with mental health problems in the Netherlands have relatively good labour market outcomes in comparison with their counterparts in other OECD countries. In 2007-09, around 68% of the population aged 15-64 with a moderate or severe mental disorder was employed – the second highest employment rate among the OECD countries shown in Figure 1.2 (Panel A) and two percentage points higher than six years earlier. Even so, the employment rate remains about 14 percentage points below the employment rate of those without mental health problems. Also the unemployment rate for people with a mental health problem is with 7% rather low compared with other OECD countries, though still twice as high as the rate for people without mental health problems, and two percentage points higher than in the early 2000s (Figure 1.2, Panel B).

Part of the good labour market outcomes should be seen against the high share of people with a mental disorder working part-time. In the Netherlands, 41% of people with a mental disorder who are working do so part-time, a share that is much higher than in other OECD countries, e.g. 10% in Denmark, 19% in the United States and 30% in Norway (Figure 1.3). Plotting the employment rate of people with a mental disorder against the share of part-time workers among them shows a clear positive relation, illustrating that more opportunities for working part-time improve the labour market outcomes for people with mental ill-health.

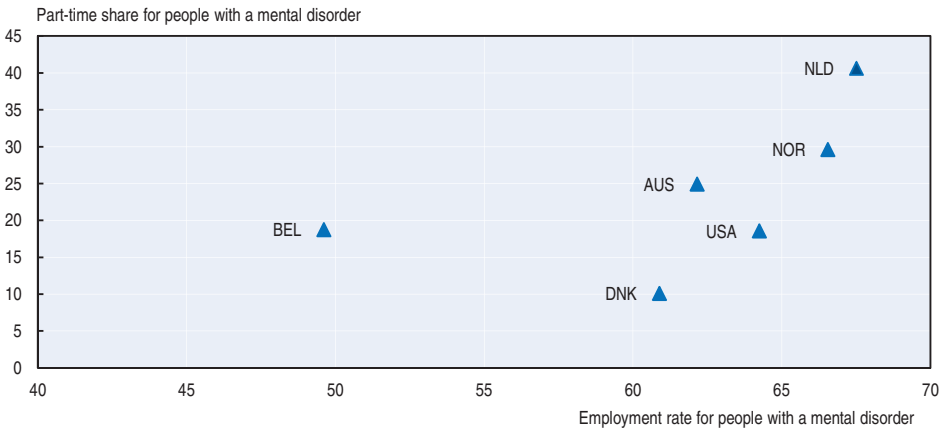
Figure 1.2. **Labour market outcomes for people with a mental disorder are rather good in the Netherlands**



Source: National health surveys. Australia: National Health Survey 2001 and 2011/12; Austria: Health Interview Survey 2006/07; Belgium: Health Interview Survey 1997 and 2008; Denmark: National Health Interview Survey 1994 and 2010; Netherlands: POLS Health Survey 2001/03 and 2007/09; Norway: Level of Living and Health Survey 1998 and 2008; Sweden: Living Conditions Survey 1994/95 and 2009/10; Switzerland: Health Survey 2002 and 2012; United Kingdom: Adult Psychiatric Morbidity Survey 2007; United States: National Health Interview Survey 1997 and 2008.

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Figure 1.3. **The higher the share of part-time workers, the better the labour market outcomes for people with mental disorders**



Note: Part-time employment is defined as persons working less than 30 usual hours per week, with the exception of Australia which refers to persons working less than 25 hours per week.

Source: OECD calculations based on data from national health surveys: Australia: ABS National Health Survey 2011/12; Belgium: Health Survey, 2008; Denmark: National Health Interview Survey 2005; Netherlands: POLS Health Survey 2007/09; Norway: Level of Living and Health Surveys, 2008; United States: National Health Interview Survey, 2008.

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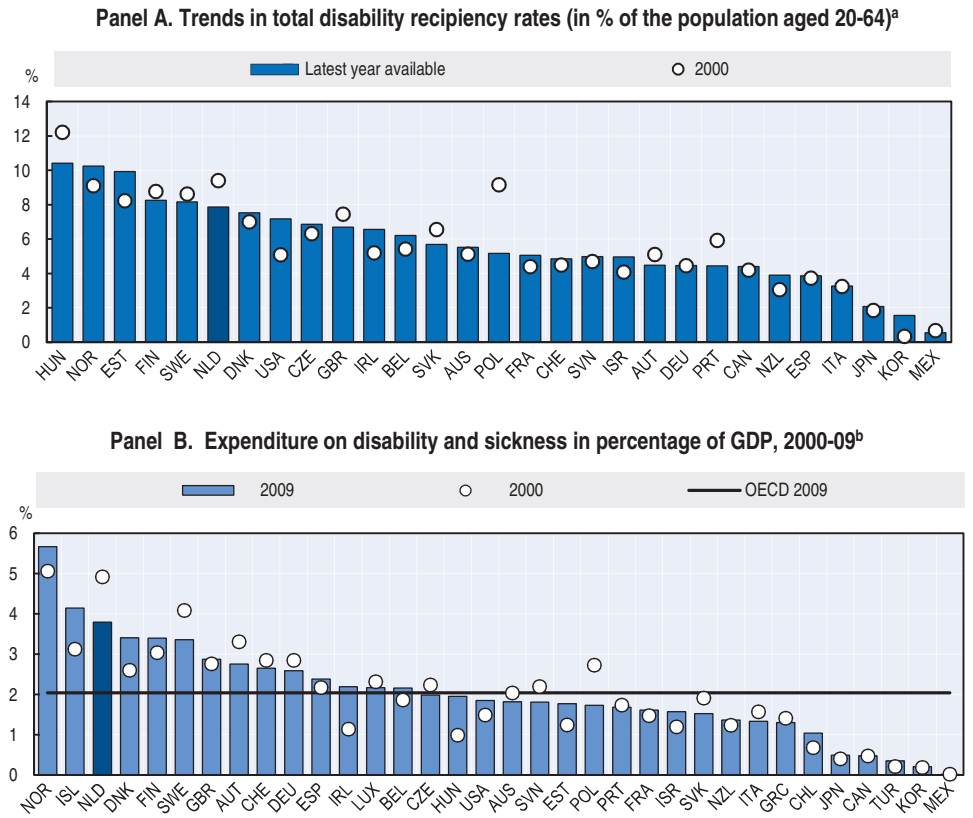
Disability benefit rates and expenditure

Despite good labour market outcomes, the Netherlands has one of the highest rates of disability benefit recipiency and expenditure among OECD countries. In 2012, 7.9% of the working-age population, or nearly 800 000 people, were receiving a disability benefit compared with 5.7% in the OECD on average (Figure 1.4, Panel A). Sickness and disability spending amounted to EUR 21.7 billion in 2009, equivalent to 3.8% of GDP, whereas the average OECD country spent only around 2% of GDP in that year (Figure 1.4, Panel B).

Much of the problem is, however, a product of the past. Indeed, in the 2000s, the Netherlands successfully reformed its sickness and disability policy through a series of very comprehensive reforms, characterised by a shift of responsibilities to employers and employees, a tightening in benefit eligibility and generosity, and a (partial) privatisation of hitherto public schemes (see OECD 2008). As a result, the inflow into disability benefits dropped from the top OECD ranking in 2002 (10 new claims per 1 000 persons) to the OECD average in 2012 (5 per 1 000) (Figure 1.5).

By mid-2000, the total number of people on disability benefits also started to fall, accompanied with a 1.1 percentage point decrease in sickness and disability expenditure (Figure 1.4, Panel A and B).

Figure 1.4. **High but declining disability benefit caseload and spending**



a. Data for 2000 refer to 2001 for Ireland, to 2002 for the Netherlands and to 2003 for Japan and Mexico.

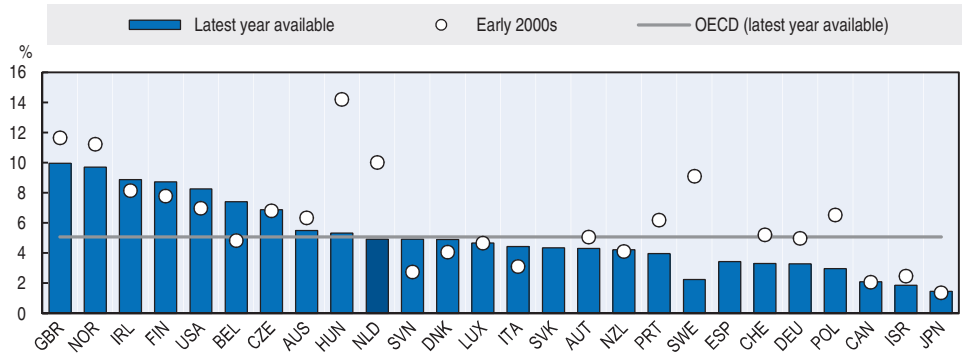
b. Data for Canada do not include spending on provincial social assistance payments with a disability designation (which would roughly double the spending figure), nor spending on voluntary private long-term disability plans. Data for Switzerland refer to 2008 instead of 2009.

Source: OECD calculations based on the *OECD questionnaire on disability* and *OECD questionnaire on mental health* for Panel A and the *OECD Social Expenditure Database (SOCX)* for Panel B.

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Figure 1.5. **New disability claims have fallen to OECD average**

New claims per 1 000 of the working-age population (inflow rates)[a]



a. Data for Canada and Spain cover the contributory benefit only and data for the United Kingdom were estimated by reducing the gross on-flow by the number of people who have been on disability benefit (previously IB, now ESA) for less than six months.

Source: OECD calculations based on the *OECD questionnaire on disability*; and *OECD questionnaire on mental health.*

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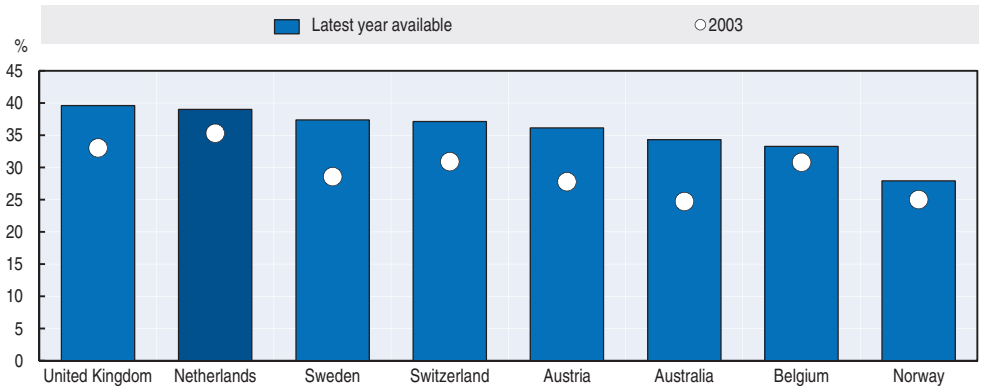
Mental health problems among benefit recipients

As in other OECD countries, mental ill-health accounts for a significant proportion of the disability beneficiary caseload in the Netherlands and the share has been increasing steadily over the past decade. Data for 2012 from the Employee Insurance Agency show that 39% of all disability beneficiaries receive a benefit on the grounds of mental ill-health as a primary condition, up from 35% in 2003 (Figure 1.6). In addition, co-morbidity of mental and somatic disorders is frequent. A small survey among disability beneficiaries reveals that one fourth has a primary somatic condition combined with a secondary mental disorder (Cornelius, 2013).

Mental ill-health does not only present a challenge for the disability benefit schemes, but also for other working-age benefit schemes. Not everyone will fulfil the strict eligibility criteria of the disability system, and many people are not even applying for such benefits because of stigma considerations. Figure 1.7 shows that among unemployed people, about one third is estimated to have a mental disorder. This observation not only holds for the Netherlands, but can also be observed in other OECD countries. Data presented in Chapter 4 indicate that mental ill-health is even more prevalent among social assistance beneficiaries; 43% of them have a mental disorder.

Figure 1.6. **Many disability benefit recipients suffer from a mental disorder**

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



a. Data for Austria, Belgium and Sweden include mental retardation, organic and unspecified disorders. Data for the Netherlands exclude Wajong benefits.

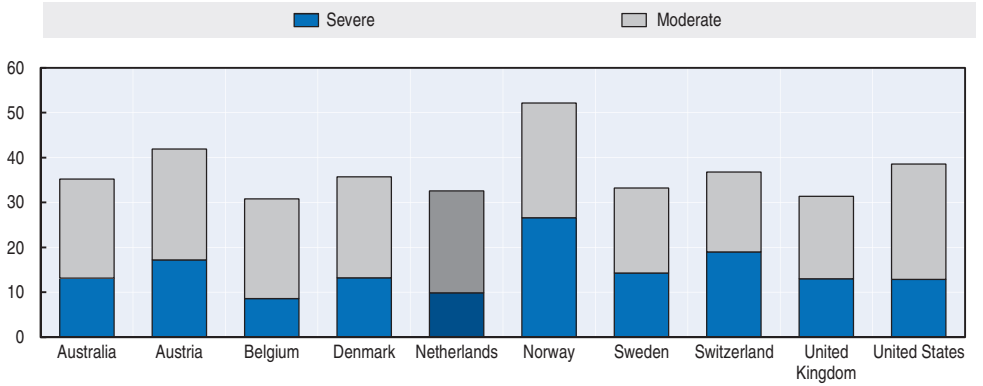
b. Data for 2003 refer to 2005 for Austria.

Source: OECD calculations based on the *OECD Questionnaire on Mental Health* and from the Employee Insurance Agency for the Netherlands.

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Figure 1.7. **Prevalence of mental disorders is high among unemployed people**

Prevalence of severe or moderate mental disorder among the unemployed (in %), latest available year



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 2010; Netherlands: POLS Health Survey 2007/09; Norway: Level of Living and Health Survey 2008; Sweden: Living Conditions Survey 2009/10; Switzerland: Health Survey 2007; United Kingdom: Adult Psychiatric Morbidity Survey 2007; United States: National Health Interview Survey 2008.

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The Dutch context: Devolution of government responsibilities

Social policy in the Netherlands has gone through an unparalleled series of reforms in the past two decades and a new major restructuring is foreseen for the coming years. An important aspect of the reforms is the decentralisation of government responsibilities to other players, in particular employers and municipalities. Also, citizens have been given more responsibilities to support themselves and actively look for work.

The first wave of decentralisation took place in the past two decades and concentrated on increasing the role of employers. By shifting the costs of the sickness and disability system onto employers, they got strong financial incentives to reduce absence from work and offer appropriate return-to-work support. This strategy proved successful as both the caseload and spending on sickness and disability benefits started falling a few years ago. Employer responsibilities continue to be extended, in the hope to reduce work incapacity among workers who are currently not fully benefiting from the employer support system (see Chapter 4).

A second wave of reforms is foreseen for 2015 and focusses on the decentralisation of various government responsibilities to the municipalities. In particular, the municipalities will become in charge of youth care, long-term care, and the support and activation of youth with disabilities. The idea behind the reforms is to create stronger incentives and opportunities to offer integrated services (e.g. employment support and social services) and to align policies across sectors at the local level. Currently, services are separately organised by different players at different institutional levels (e.g. municipal, regional or national level) and often focus on one aspect of the problem, while many clients are in contact with several services and would benefit from an integrated approach.

The decentralisation to municipalities has potential but with considerable limitations. Municipalities have an important advantage of proximity to the clients. Through a concentration of responsibilities at the local level, municipalities will be better able to adapt their services to the demand and reduce duplication of services. A second strength of the decentralisation is that municipalities have strong financial incentives to deliver good services as they will become responsible for their own budget. For instance, the strategy to reduce the social assistance caseload by encouraging young people with a mental disorder to apply for a disability benefit will no longer be beneficial as municipalities will become in charge of this group as well. Nonetheless, the decentralisation comes with a scale disadvantage as many municipalities operate on a very small scale. Co-operation with neighbouring municipalities may offset that scale problem but increase again the complexity of service delivery.

Finally, there is a risk of considerable differences in quality and level of support across municipalities, which calls for close monitoring by the national government.

Conclusions

To summarise, the following key facts emerge in comparing the Dutch outcomes with those in other OECD countries:

- Labour market outcomes of people with mental health problems are relatively good in the Netherlands. With an employment rate of 68% for people with a mental disorder, the Netherlands is among the better performing countries.
- Dependence on disability benefits remains high, but the reforms in the past two decades, through which considerable responsibilities were transferred to employers and employees, successfully managed to reduce the number of new claims.
- Mental illnesses are omnipresent in all working-age benefit systems, including unemployment benefits, sickness and disability benefits, and social assistance.
- Further devolution of governmental responsibilities to the municipal level has potential but will require careful monitoring of incentives and actions to assure better outcomes.

Notes

1. Mental disorders, as defined in the report of Gustavsson et al. (2011), exclude intellectual disabilities which encompass various intellectual deficits, including mental retardation, various specific conditions such as specific learning disability, and problems acquired later in life through brain injuries or neurodegenerative diseases like dementia. Organic mental illnesses are also outside the scope of this report.
2. Indirect costs in this study include productivity losses and the costs of benefits; direct medical costs include goods and services related to the prevention, diagnosis and treatment of a disorder; and direct non-medical costs are all other goods and services related to the disorder, e.g. social services.
3. The diagnosis also matters, but any mental illness can be severe, persistent or co-morbid. The majority of mental disorders fall in the category mild or moderate, including most mood and anxiety disorders.

References

Cornelius, B. (2013), "A View Beyond the Horizon: A Prospective Cohort Study on Mental Health and Long-term Disability", Proefschrift ter verkrijgen van het doctoraat in de Medische Wetenschappen, Rijksuniversiteit Groningen.

Gustavsson, A., M. Svensson, F. Jacobi et al. (2011), "Cost of Disorders of the Brain in Europe 2010", *European Neuropsychopharmacology*, vol. 21, pp. 718-779.

OECD (2012), *Sick on the Job? Myths and Realities about Mental Health and Work*, OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264124523-en.

OECD (2008), *Sickness, Disability and Work: Breaking the Barriers. Vol. 3: Denmark, Finland, Ireland and the Netherlands*, OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264049826-en.

Chapter 2

Mental health of Dutch youth and the transition into the labour market

This chapter assesses the capacity of the Dutch system to support youth with mental health problems to acquire an educational qualification and to successfully transition into the labour market. It first discusses the school services that are available to identify and support youth with mental health problems in education and explains the youth care system. Second, strategies to tackle early school leaving are described. Finally, the transition of youth into the labour market is discussed, including an examination of the services that are provided to support this transition.

Prevention of mental health problems in childhood and adolescence is of paramount importance as the median age of onset of all mental disorders is about 14 years (OECD, 2012). This is not only the case for the more severe mental disorders, but also for mild-to-moderate mental disorders. For example, the risk for a depressive disorder in adulthood increases when depressive symptoms have occurred during adolescence (Pine et al., 1999). Moreover, youth with mental health problems are often confronted with impairments in several life domains such as family, school and social functioning (Jaycox et al., 2009). The vulnerability of youth with mental health problems asks for pro-active policies to prevent the development of full-blown mental disorders and to provide support to those who are confronted with mental health problems to realise educational attainment and a successful transition into the labour market.

The following sections focus on the available youth support systems in the Netherlands, and, in particular, on the role of the education and the youth care system in identifying and supporting vulnerable youth with socio-emotional or behavioural problems. Additionally, Dutch policy regarding two prerequisites for good labour market outcomes for youth, i.e. the prevention of leaving school early and enabling a smooth transition into the labour market, are evaluated. Box 2.1 first provides a description of the Dutch education system.

Box 2.1. **The Dutch education system**

In the Netherlands, primary and secondary schools are free of charge and the government funds schools. Compulsory education runs from the age of 5 to 16, with a qualification obligation from 16 to 18 years (OCW, 2007). The qualification obligation entails that youth until the age of 18 are obliged to follow education until they have attained a basic qualification, which is defined as a HAVO, VWO or MBO level 2 diploma (see below for further explanation).

Primary schools take up eight years and most pupils finish their primary education at age 12 (the majority starts with the first year of school at age 4 before the compulsory age of 5). At the end of primary school, pupils receive an advice on which of the three learning paths in secondary school would be the most appropriate given the school results and capacities of the pupil. The three learning paths are: i) intermediate pre-vocational education (VMBO) lasting four years; ii) higher general education (HAVO) lasting five years; and iii) scientific preparatory education (VWO) lasting six years (OECD, 2008). Most secondary schools are combined schools, which makes it possible to have the first one or two years of secondary education as common as possible before differentiating between the different learning paths. During these years pupils can switch from one type of secondary education to the other. Intermediate pre-vocational education is meant as preparation for vocational education (MBO), higher general education as preparation for higher vocational education (HBO) and scientific preparatory education as preparation for university (WO). However, pupils from the intermediate pre-vocational education can also choose to go on to higher general education and from there to higher vocational education, and pupils from higher general education can choose to go on to scientific preparatory education and from there to university (OCW, 2011a).

The role of the education system in tackling mental ill-health

The education system plays an important role in the prevention and control of mental health problems. About one in five Dutch youth aged 11-18 years report internalising (i.e. emotional) and externalising (i.e. behavioural) problems. Moreover, 10.5% reports any kind of anxiety disorder and 4.6% any kind of mood disorder (Trimbos-instituut, 2010). Thus, a substantial part of youth needs to deal with mental ill-health during their school years.

In the Netherlands, a strong focus has been placed on developing support systems in and around primary, secondary and vocational schools. As from August 2014, the new act on appropriate education (Wet Passend Onderwijs) has been enforced for primary, secondary (i.e. pre-vocational, higher general and scientific preparatory education) and vocational education. This act arranges that schools in the same region are combined in collaborative alliances. With the help of these alliances, schools need to fulfil their duty of care as described in the act. The alliances receive funding from the government to arrange facilities to support children with special needs. Moreover, schools need to develop care plans that are aligned with the municipalities, which are responsible for youth care.[1]

Already before the implementation of the new act on appropriate education, many schools in primary, secondary and vocational education had internal care teams and took part in regional care and advice teams (ZAT). Figure 2.1 shows the coverage level for the different education systems. In what follows, more detailed information is provided on the school support system in primary, secondary, vocational and special education.

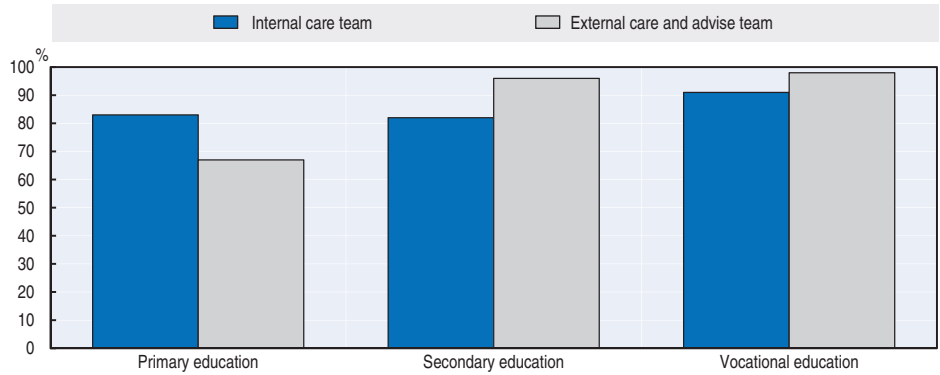
Supports in primary, secondary and vocational education

Internal care teams

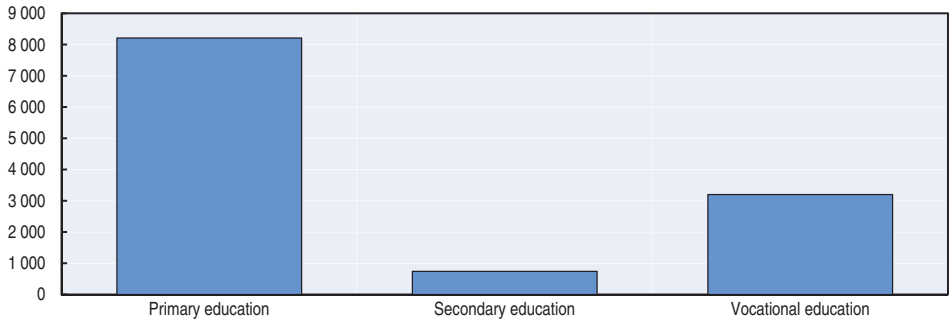
As shown in Figure 2.1, Panel A, internal care teams are available in most schools. In primary and secondary education, about 80% of the schools have an internal care team and in vocational education about 90%. Internal care teams consist of an internal care manager (from the school) and often a school social worker (for 74%, 56% and 100% of the teams in primary, secondary and vocational education, respectively). In primary education, 53% of the teams also include a youth health care professional. A pedagogue or psychologist takes part in 43% and 50% of the teams in primary and secondary education, respectively. Care teams assess signals of emotional or behavioural problems and educational and care needs, initiate the provision of help to children and parents and provide support to teachers (van der Steenhoven and van Veen, 2011a; van der Steenhoven and van Veen, 2011b; van der Steenhoven and van Veen, 2012).

Figure 2.1. **The majority of primary, secondary and vocational schools involve care teams**

Panel A. Percentage of schools with internal care teams and participating in external care and advice teams, 2010



Panel B. Caseload per external care and advice team, 2010



Source: van der Steenhoven, P. and D. van Veen (2012), "Monitor deelnemerszorg en ZAT's in het middelbaar beroepsonderwijs 2011", Nederlands Jeugdinstituut, Utrecht; van der Steenhoven, P. and D. van Veen (2011a), "Monitor ZAT's, zorgteams en leerlingenzorg in het primair onderwijs 2010", Nederlands Jeugdinstituut, Utrecht; van der Steenhoven, P. and D. van Veen (2011b), "Monitor leerlingenzorg en ZAT's in het voortgezet onderwijs 2010", Nederlands Jeugdinstituut, Utrecht.

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Other forms of support are also available in complement to the internal care team. In secondary education, 89% of the schools have a confidant. Many vocational schools (84%) have a "care commissioner" who has special knowledge on providing psychosocial guidance and supports the school's career coaches in conducting their mentoring role. School social work is a basic provision in vocational education since 2010 and subsidised by the government. The average capacity for social work per vocational

school is 4.4 full-time equivalents (FTE) and the number of students per FTE social worker is 2 610. In 84% of the vocational schools, tools are used for the inflow of students of whom it is known or expected that they have psychosocial or learning problems (e.g. extended intake interview when entering the school to make an inventory of problems and selecting appropriate support programs). Finally, 95% of the vocational schools report providing preventive services in co-operation with other care providers such as mental health care consultations, guidance in case of truancy and debt services (van der Steenhoven and van Veen, 2011a; van der Steenhoven and van Veen, 2011b; van der Steenhoven and van Veen, 2012).

External care and advice teams

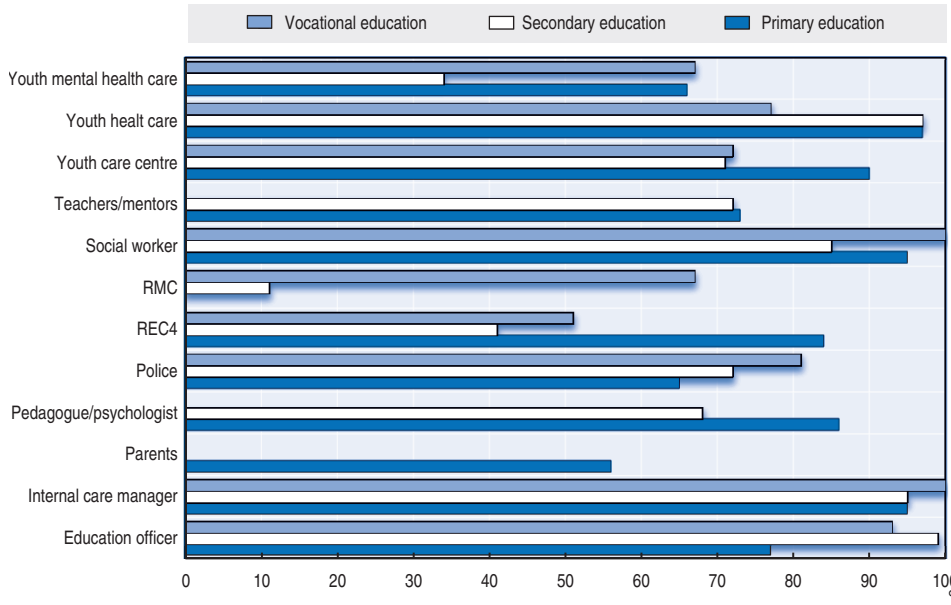
The external care and advice teams are available for more serious and complex problems. The teams are organised at the regional level through collaborative alliances between schools and include youth (mental health) care specialists. Several parties can be part of a care and advice team. Figure 2.1 shows that external care and advice teams are available for almost all secondary and vocational schools but for a much smaller group of primary schools (only 67% takes part in a care and advice team). When looking at the combination of internal care teams and external care and advice teams for primary schools, 55% have both internal and external teams and 3% have none.

Composition

Figure 2.2 shows the participation rate of different parties in care and advice teams in primary, secondary and vocational education. In secondary education, the education officer plays an important role, taking part in 97% of the care and advice teams. This is due to the fact that the education officer is responsible for controlling truancy, which is more common in secondary than in primary education. A relatively important party in vocational care and advice teams are the Regional Register Centres (RMC) who are responsible for guiding students who have left school early (this is especially a problem in vocational education). Parents are invited to take part in meetings of care and advice teams about their child only in primary education. Communication between the external care and advice teams and the internal care teams is ensured through participation of the school's internal care manager in the external care and advice team (van der Steenhoven and van Veen, 2011a; van der Steenhoven and van Veen, 2011b; van der Steenhoven and van Veen, 2012).

Figure 2.2. **Composition of external care and advice teams in primary, secondary and vocational education**

Share of expert parties participating in care and advice teams, in percentages, 2010



Note: REC4 = regional expert centre focused on children with severe psychiatric and/or behavioural problems; RMC = regional centres co-ordinating care for early school leavers.

Source: van der Steenhoven, P. and D. van Veen (2012), "Monitor deelnemerszorg en ZAT's in het middelbaar beroepsonderwijs 2011", Nederlands Jeugdinstituut, Utrecht; van der Steenhoven, P. and D. van Veen (2011b), "Monitor leerlingenzorg en ZAT's in het voortgezet onderwijs 2010", Nederlands Jeugdinstituut, Utrecht.

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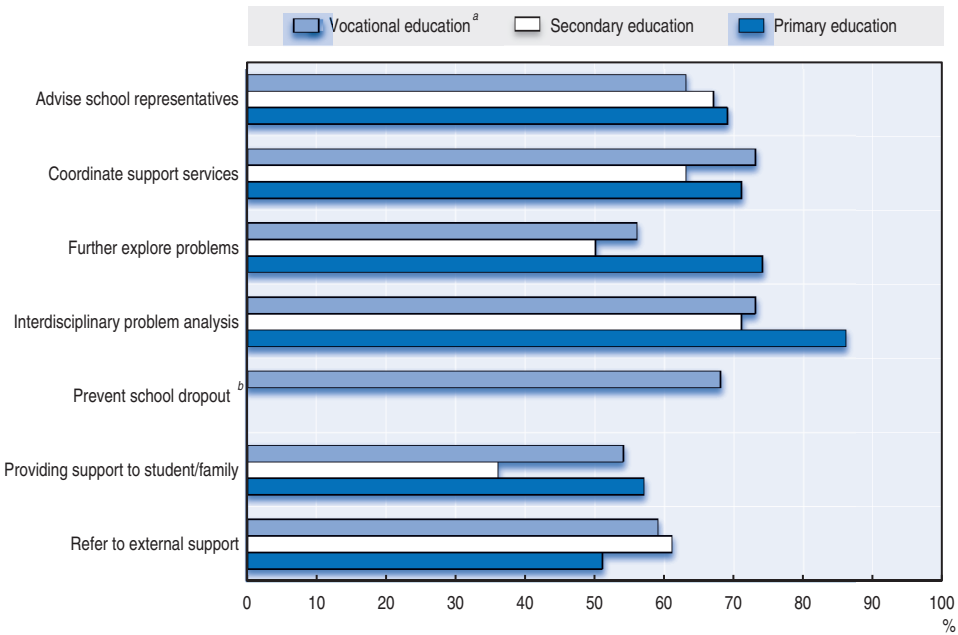
Main tasks

There are four main tasks that are conducted by the majority of care and advice teams: i) conduct interdisciplinary problem analysis of the cases that are brought in by the participating parties; ii) further explore problems of students or families through conversations, screening and diagnosing; iii) co-ordinate the support services that are necessary for a specific case; and iv) advise the school representatives of the case that was brought in. Additionally, in primary education, 57% of the teams provide treatment/support to students and/or the family and 51% has contact with the school and/or parents about the progress and agreements that were made (van der Steenhoven and van Veen, 2011a). In secondary and vocational

education, external care and advice teams also frequently refer cases to external support services. Additional tasks of the teams in vocational education is the prevention of early school leaving (68% of the teams frequently focus on this) and, to a lesser extent, guiding vulnerable students in making a transition into the labour market (17% of the teams frequently focus on this) (van der Steenhoven and van Veen, 2011b; van der Steenhoven and van Veen, 2012).

Figure 2.3. **Main tasks of external care and advice teams in primary, secondary and vocational education**

Tasks frequently performed, in percentages, 2010



a. Data for vocational education are from 2011.

b. No data available on the prevention of early school leaving for primary and secondary education.

Source: van der Steenhoven, P. and D. van Veen (2012), "Monitor deelnemerszorg en ZAT's in het middelbaar beroepsonderwijs 2011", Nederlands Jeugdinstituut, Utrecht; van der Steenhoven, P. and D. van Veen (2011a), "Monitor ZAT's, zorgteams en leerlingenzorg in het primair onderwijs 2010", Nederlands Jeugdinstituut, Utrecht; van der Steenhoven, P. and D. van Veen (2011b), "Monitor leerlingenzorg en ZAT's in het voortgezet onderwijs 2010", Nederlands Jeugdinstituut, Utrecht.

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Caseload

The caseload of care and advice teams differs per educational level. In primary education, each team covers on average 8 200 pupils, while for secondary and vocational education this number is 721 and 3 200 students, respectively (see Figure 2.1, Panel B). The number of cases discussed is, on average, 77 over one school year per team in primary education, 30 per team in secondary education and 36 per team in vocational education. Of the total primary school population, about 1% of all pupils are discussed in one school year, for secondary education this is 4% (no numbers are available for vocational education). In primary education, the main problems presented by the cases are (in order of frequency): i) developmental disorders; ii) behavioural problems in combination with learning problems; iii) unmanageable behaviour; and iv) parenting problems (i.e. problems with child rearing) (van der Steenhoven and van Veen, 2011a). In secondary education different problems are presented: (in order of frequency): i) parenting problems; ii) worrisome school absenteeism; iii) unmanageable behaviour; and iv) family problems (van der Steenhoven and van Veen, 2011b).

Evaluation

Each year, an evaluation takes place of the care and advice teams. The evaluation shows that the teams are functioning well on several aspects, but that there are also important shortcomings. Overall, teams in primary, secondary and vocational education are rated well in terms of expertise, collaboration within the team, clear administration and reporting on agreements, quick mobilisation of help and effective problem management. However, for teams in primary and secondary education, problems are encountered with the implementation of preventive programs in schools and the limited scale on which the teams provide support programs. The most important points for improvement according to the primary schools are the co-operation of the teams with local youth care parties and the embedment of the teams in the local youth care infrastructure (van der Steenhoven and van Veen, 2011a). Contrary, in secondary and vocational education, the teams are very positively rated on good collaboration with the school and external parties in youth care. Some problems that are specifically encountered in secondary education are feedback from the care and advice teams to the students, parents and teachers, and minimal reduction of school absenteeism after intervention by the team (van der Steenhoven and van Veen, 2011b). Problem areas of the teams in vocational education are: timely referral of students to the care and advice teams and to other external parties (e.g. mental health care), possibility for teachers to consult the teams and receiving feedback from external parties (van der Steenhoven and van Veen, 2012).

Both the internal care teams and the external care and advice teams have only limited resources available for a large group of students. The caseload for the external care and advice teams is high, especially in primary and vocational education. Moreover, each team only comes together a couple of times per year (for external teams, on average, 16 times per year in primary education, eight times in secondary and seven times in vocational education). Thus, professionals in these teams are not available fulltime for schools. Looking at the percentage of the total school population that is being discussed in the external teams (1% and 4% in primary and secondary education, respectively), a large group of students with problems is being missed as national data have shown that about 20% of the Dutch youth experience mental health problems. Only the cases with more severe problems will be discussed in the teams, while students struggling with mild-to-moderate problems will not receive care from these teams.

Finally, the inability of external care and advice teams to contribute to preventive programs to promote good (mental) health is worrying. Quick intervention for the visible, more severe problems, which seems to be working well in the teams, is important, but preventive activities are essential to keep students mentally healthy and can help to reduce the total caseload of the teams. A good example of an effective prevention programme for schools that might also work in the Netherlands is the KidsMatter programme coming from Australia (see Box 2.2).

Box 2.2. **The *KidsMatter* programme in Australian schools**

KidsMatter broadly aims to encourage partnerships between education, early childhood and health and community sectors to optimise children's mental health and wellbeing. *KidsMatter* has two sub-programs, *KidsMatter Early Childhood* and *KidsMatter Primary*.

KidsMatter Early Childhood is run in preschools, kindergartens and long day care services and aims to inform and support early childhood education and care practice. This is done by providing resources, tools and reflective opportunities, and by connecting educators, children, families, management, and community and health professionals.

KidsMatter Primary is run in primary schools and uses a whole-school approach including a framework, an implementation process and key resources (information sheets for stakeholders) to develop and implement evidence-based mental health promotion, prevention and early intervention strategies. The framework consists of four key areas or components: positive school community; social and emotional learning for students; parenting support and education; and early intervention for students experiencing mental health difficulties. These components aim to help improve the mental health and wellbeing of primary school students; reduce mental health problems in students; and achieve greater support for students with mental health problems and their families.

Box 2.2. **The *KidsMatter* programme in Australian schools** *(cont.)*

A comprehensive evaluation of *KidsMatter* conducted in 2009 found a general improvement in student mental health and wellbeing, including optimism, coping skills and behaviours, as well an improved capacity and knowledge of teachers (Slee et al., 2009). A similar program, called *MindMatters*, exists for secondary schools.

Source: OECD (forthcoming), *Mental Health and Work: Australia,* OECD Publishing, Paris.

The organisation of special education

Since August 2014 (the start of the new school year), new legislation has been implemented for organising primary and secondary education for students with special needs due to the high costs and complexity of the old system. Before August 2014, parents of children with special needs (e.g. visual, auditory, physical, intellectual or mental disabilities) had to apply for an assessment of special needs at regional expert centres. If the centre deemed the child as having special needs that require extra support at school, the parents could choose to have their child enrolled at a school for special education or at a mainstream school that would then receive money, the so-called "backpack", to provide the extra support necessary for the child. Figure 2.4 shows that within ten years, the number of children in special education grew from 54 000 to about 70 000, reaching 2% of all youth in 2013 (Rijksinstituut voor Volksgezondheid en Milieu, 2013). This growth is mainly due to the increase in secondary special education of cluster 4 students, which are students with mental disorders or severe behavioural problems. Additionally, in the same period, the number of students with a "backpack" grew from 11 000 to 39 000 (Rijksinstituut voor Volksgezondheid en Milieu, 2013).

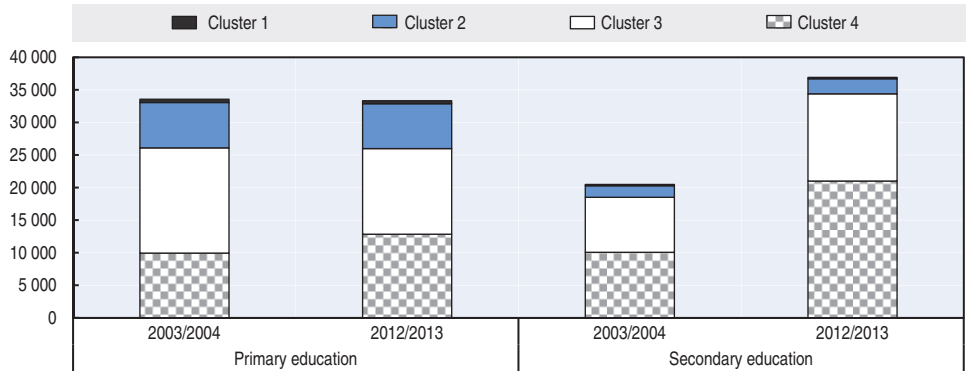
The new act on appropriate education is developed around two main premises: the school has a duty for care and schools in the same region need to collaborate. Parents can now enlist their child at the school of their preference, and within 6 to 10 weeks the school needs to arrange appropriate education within the school, in another regular school or in a special school within the same region. Each school develops a "school support profile" in which they report what kind of educational support they are able to offer and teachers in regular schools are educated to deal with students with different needs to ensure most students can go to regular schools. In total, 152 regional school alliances are formed in primary and secondary education. They receive financing from the government to provide light and intensive support to students with special educational needs. Government financing for such support is divided over the alliances following the

number of students within the alliance. The school alliances divide the resources over the schools that provide extra support measures. Part of the financing goes to the special schools, depending on how many students in the alliance are in special education.[2]

Whether the new act will result in: i) including more students with special needs in regular education; and ii) facilitate matching between students with specific special needs and schools with the right support services needs to be seen in the coming years.

Figure 2.4. **Strong increase of students in secondary special education**

Number of students in primary and secondary special education in school years 2003/04 and 2012/13



Note: Cluster 1 = visual disabilities, cluster 2 = auditory and communicative disabilities, cluster 3 = physical and intellectual disabilities, cluster 4 = mental disorders and severe behavioural problems

Source: Statistics Netherlands (2014a), Den Haag/Heerlen, http://statline.cbs.nl/StatWeb/publication/?DM=SLNL&PA=37746SOL&D1=0&D2=0-45&D3=a&D4=12,l&HDR=T,G3,G2&STB=G1&VW=T (accessed 26 March 2014).

StatLink http://dx.doi.org/10.1787/888933145460

A new policy for youth care to reduce scattered services

Youth care in the Netherlands has been very scattered with many different institutions and expertise centres providing some form of support through different ways of financing (see Box 2.3 for an overview of the key institutions within youth care). Institutions such as the youth care centre, the centre for youth and family, and the care and advice team can all provide forms of primary (mental health) care. Due to this diversity of services, it has become unclear where parents need to go to find the most suitable care when their child struggles with behavioural or mental health problems. In 2005, the Act on Youth Care was implemented, which stated that the youth care centre would become the main entrance point to psychosocial care for youth. The centre was

also provided with the authority to refer youth to specialised mental health care. However, an evaluation in 2009 showed that this system was not working (BMC, 2009). The majority of the parents continue to go to their general practitioner (GP) to find proper treatment for their child, and most children are directly referred to specialised mental health care while some could also be treated in primary youth care. Consequently, due to the high costs of specialised care, mental health care expenses for youth increased drastically.

Box 2.3. **Main institutions for youth care in the Netherlands**

Youth care centres

Youth care centres (in Dutch: *Bureau Jeugdzorg*) are located in each Dutch province and additionally in the three main cities (Amsterdam, Rotterdam and Den Haag). These bureaus form an entrance point to all youth care and are financed by the government. Youth until the age of 18 and their parents can freely ask for care. Employees at the bureau assess what kind of care would be suitable and can provide (primary) treatment themselves or refer children/parents to other (specialised) health care providers. The bureaus are also responsible for registering and acting against child abuse and for executing youth protection measures. Most employees at the youth care centre are curatorship workers (32%) or youth care workers (e.g. social workers, 20%). Only 5% of the personnel is a psychologist, pedagogue or medical doctor (Jeugdzorg Nederland, 2013, www.bureaujeugdzorg.nl accessed 28 March 2014).

Centres for youth and family

Centres for youth and family (in Dutch: *Centrum voor Jeugd en Gezin*) are available in each municipality and financed by the government. The goal of these centres is to provide an easy accessible meeting place, close to home, where parents and youth can get information, advice and help with growing up, child development and raising. Issues that can be discussed are, for example, the development of children, child diseases, behavioural problems or how to raise a child. The main tasks of the centres are: i) signalling, analysing and, if needed, referring to (specialised) care; ii) supporting and providing information, advice and care (i.e. light pedagogical care such as courses, training or coaching related to child development/raising); iii) organising integrated care; and iv) monitoring, screening and vaccinating. Several specialists work in the centres, such as paediatricians, nurses for youth care, psychologists, pedagogues and social workers (Jeugd en Gezin, 2010).

Youth mental health care

Youth mental health care (in Dutch: *jeugd-ggz*) is arranged through youth departments within the existing specialised mental health care centres for adults. Here, psychiatrists, psychotherapists/psychologists and mental health care nurses collaborate to provide specialised treatment for youth with mental disorders. Only GPs, medical specialists and the youth care centres can refer youth to these specialised mental health care centres. Treatment is covered by health insurance if the child has been diagnosed with a mental disorder (after 2014, municipalities will finance specialised mental health care for youth as described in the section below on decentralisation; www.ggznederland.nl/themas/jeugd-ggz accessed 28 March 2014).

Box 2.3. **Main institutions for youth care in the Netherlands** *(cont.)*

Care and advice teams

Care and advice teams (in Dutch: *Zorg en Advies Teams*) are regional collaborations between schools and external parties (e.g. social work, youth health care, youth mental health care and police) to provide support to children who have presented themselves with psychosocial, behavioural or learning problems within the school environment. These children are brought in as cases into the multidisciplinary ZAT. The main tasks and performance of these teams are discussed above.

Decentralisation of youth care to municipalities as from 2015

To reduce the costs of specialised mental health care and to assure that children receive proper treatment (i.e. not more intensive then necessary, but in line with their needs) close to home, the government decided to decentralise all forms of youth care to municipalities as of 2015 through the new Youth Act. With this new act, municipalities have a "care duty" meaning that they need to provide appropriate care for all youth who apply for help. The centres for youth and family will remain an important player in this structure to help fulfil the municipalities' following responsibilities: i) provide easy access to youth care; ii) initiate youth care close to home; iii) initiate appropriate care and expertise in a timely manner; iv) provide consultations; v) co-ordinate care; vi) assure 24-hour reachability and possibility of direct intervention in crisis situations; and vii) assure quick involvement of specialist care in case of complex problems or when the child's safety is at stake (VWS, 2012).

Youth mental health care will come under the responsibility of the municipality and funding to buy services from (specialised) mental health care providers will be received from the government. The most important argument for transferring specialised youth mental health care to the municipalities is that municipalities will be integrally responsible for all forms of support and care for youth. By decentralising specialised youth mental health care, opportunities arise for integrated care to youth with problems in several areas such as school, family and mental health, and municipalities will have more control over care. Additionally, the municipalities should have a financial incentive to invest in self-management, preventive mental health care and lighter forms of care, as these provisions would reduce the use of the more expensive specialised mental health care. The provincial youth care centres will not receive funding from the government anymore and will only remain to exist as long as municipalities decide to buy there specialised serves (VWS, 2012).

Although the central argument for decentralising youth care – i.e. better integration and co-ordination of care and providing care close to home – is supported by most parties involved, several concerns have been raised. First, by transferring (specialised) youth mental health care to the municipalities, the sector is disconnected from youth somatic care, which is still arranged through the health insurance. Research has shown that over 50% of the youth treated in specialised mental health care also received specialised somatic care (van Gastel, 2012). Difficulties may thus arise in co-ordinating somatic and mental health care, and municipalities and health insurers need to collaborate in this. Second, a similar disconnection is introduced between adult and youth mental health care as adult mental health care also remains financed through the health insurance. Finally, problems may arise because, in addition to the municipal teams, also GPs, youth health care physicians and other medical specialists will be able to refer youth directly to (specialised) mental health care services, such as psychologists or psychiatric centres, without interference of the municipal team. As the municipality will be responsible for paying for the mental health care services it needs to have some form of control over referral, but agreements on co-ordination with GPs and other medical specialists still need to be arranged (VWS and VJ, 2013).

Investments have been made to reduce the number of early school leavers

Leaving school early seriously reduces labour market opportunities for youth. In the Netherlands, early school leavers (ESL) are two times more likely to be unemployed and six times more likely to be involved in criminal activities compared to youth with a basic qualification (OCW, 2011b; Traag et al., 2010). With an ESL rate of 15.4% in 2000, ESL in the Netherlands had to be tackled to reach the EU goal of an 8% ESL rate by 2012, as recorded in the Lissabon agreement (OCW, 2011b).

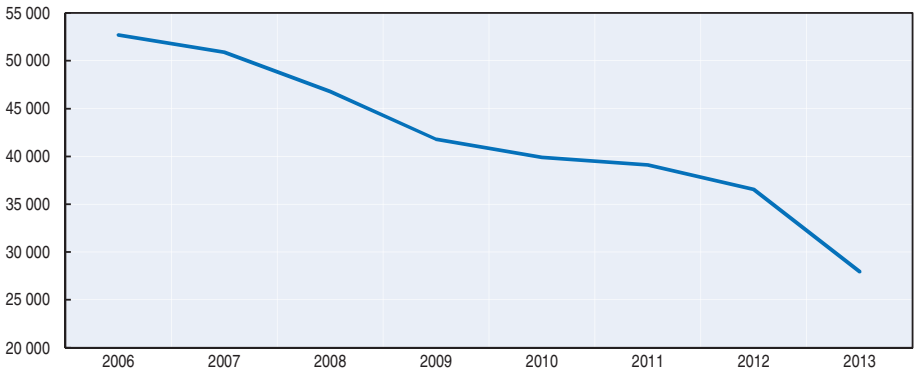
Since 2007, several measures have been implemented to reduce ESL. First, the qualification obligation was introduced for youth aged 16 to 18 who have no basic qualification (see also Box 2.1). Second, all youth in education received an "education number", which facilitated registration of ESL. In line with this, a national digital "school absenteeism desk" was developed where all schools could report school absenteeism (unauthorised school absenteeism is defined as missing 16 school hours within four consecutive school weeks) and ESL (defined as quitting school before having acquired a basic qualification). Since 2009, all schools have been obliged to report absenteeism/ESL at this desk. Third, a national program called "Aanval op schooluitval" (i.e. attacking ESL) was started. With this program, 39 regional register and co-ordination centres were set up to tackle early school leaving in the region, in collaboration with schools and

municipalities through covenants. The main targets of the program are: i) extra attention for the transition from pre-vocational secondary education to vocational education; ii) more and better care at school through financial incentives (see below); iii) more possibilities for youth who rather "work with their hands" and more tailor-made education; iv) better support in career orientation and study choice; v) more attractive education, including sports and culture, to keep youth in school; and vi) agreements with big employers aimed at reaching a basic qualification for ESL aged 18 to 23 (OCW, 2011b*)*. Finally, schools receive financial rewards if they reach the norms for lowering ESL percentages. Each year, the government makes EUR 114 million available for regional/school programs aimed at the prevention of ESL (OCW, 2013).

A clear downward trend can be observed in the number of new ESL per school year since the measures tackling ESL have been implemented. Figure 2.4 shows that the number of new ESL has almost halved from over 50 000 in school year 2005-06 to around 28 000 in 2012-13, which is 2.1% of the total school population (preliminary numbers). The majority of the ESL (79%) come from vocational education, 18% from secondary education and the remaining 3% from adult education.

Figure 2.5. **Number of early school leavers has decreased substantially**

Number of students who dropped out of school, school year 2005/06 to 2012/13



Note: Only the numbers of new early school leavers per school year are presented.

Source: OCW (2014), *VSV Verkenner – Zoom in op schooluitval*, Den Haag, www.vsvverkenner.nl, (accessed 26 March 2014).

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Students under the age of 23 who leave school without a basic qualification fall under the responsibility of the regional register and co-ordination centre. The centre focuses on guiding these students back to education, possibly in combination with work, to obtain a basic qualification, or, if education is no longer feasible, to help them finding a sustainable job (often in co-operation with UWV). The guidance of ESL follows the following steps:[3] i) detect and contact the ESL; ii) intake interview and start guidance; iii) present possible opportunities; iv) mediate between parties (e.g. school, parents and student) where necessary and provide advice; v) develop an action plan (including referral to other youth care providers if needed); vi) sign a trajectory agreement with the ESL; and vii) provide after care, once the ESL has enrolled in the selected trajectory. Each year, evaluation reports have to be delivered by the centres, which show how many ESL were supported back to school or work. However, these reports provide no information on the number of ESL who eventually succeed in attaining a basic qualification. Data from Statistics Netherlands show that only a small percentage of the ESL return to school; 25% in the first two years after leaving school up to 30% in the following years. An even smaller percentage attains a basic qualification; only 22% within seven years after leaving school. This pattern has been stable for ESL over the years 2005 up to 2009 and no change can be observed after the implementation of the regional register and co-ordination centres (no data available from Statistics Netherlands on the return to school of ESL after 2009 (CBS, 2012).

Youth with mental health problems form a high risk group

Research has shown that youth with mental health problems are an important risk group for leaving school early and lower educational attainment (also after controlling for socio-economic variables) (McLeod and Fettes, 2007; Fletcher, 2008; Veldman, 2014). Reasons for school absenteeism and leaving school early among adolescents with mental health problems are mood problems (e.g. not motivated, anxiety), negative relationships with peers at school (e.g. being bullied), insufficient support from school and waiting lists to enrol in special education (Rijksinstituut voor Volksgezondheid en Milieu, 2013). Additionally, these youth hold lower (educational) expectations for themselves, which contributes to the risk of lower educational attainment (McLeod and Fettes, 2007).

Insufficient attention for the problems specific to youth with mental health problems impedes proper ESL policy. For example, research suggests that teachers tend to lower expectations for youth with mental health problems, reinforcing these thoughts in the youths themselves and this way contributing to lower educational attainment (McLeod, 2007). Also, lower expectations might be an important obstacle for realising a return to

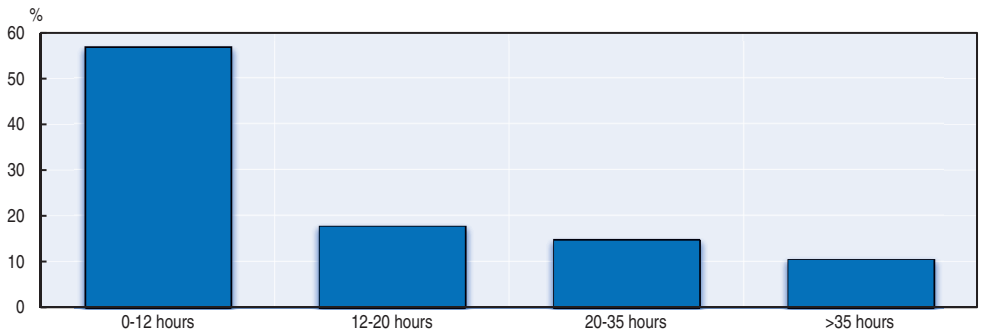
education after leaving school early. Additionally problematic is that youth with emotional problems (e.g. depressive feelings), as opposed to youth with behavioural problems (e.g. aggressive behaviour), are less visible because they do not disturb the school system and more easily disappear from sight when being absent from school (Rijksinstituut voor Volksgezondheid en Milieu, 2013). Failing to incorporate these issues in the generic ESL policy measures will reduce the chances of educational attainment for youth with mental health problems.

Transition into the labour market

Compared with the average OECD youth unemployment rate of 16.3%, the Netherlands are doing well with only 9.5% youth unemployment in 2012 (OECD, 2013). Dutch youth already acquire work experience at a young age as many have (part-time) jobs while studying. Figure 2.6 shows the distribution of the number of hours worked by Dutch youth aged 15 to 25 years. About 40% of young people who combine studies and a job work 12 hours or more per week. Among those working over 20 hours per week, the majority probably follow a practice-oriented learning path in vocational education where students go to school for one day and work in a certified training company during the other days of the week.

Figure 2.6. **Many youth work but typically only a few hours a week**

Working hours of youth aged 15-25 combining work and education, in percentages, 2011



Source: Statistics Netherlands (2014), "Personen met of zonder startkwalificatie voor de arbeidsmarkt" [Persons with or without a basic qualification for the labour market], Statistics Netherlands, Den Haag/Heerlen, http://statline.cbs.nl/StatWeb/publication/?DM=SLNL&PA=80171NED&D1=0&D2=1&D3=1&D4=17-24,29-39&D5=0,10-11&HDR=T,G4&STB=G1,G2,G3&VW=T (accessed 28 March 2014).

StatLink http://dx.doi.org/10.1787/888933145488

Policies and initiatives to support youth in their transition from education into the labour market mainly focus on youth in special (vocational) education and on youth on disability benefits as they are more vulnerable compared with youth in higher vocational education and university. Also, for students as from the age of 12 years who are expected to be unable to attain a pre-vocational diploma (i.e. strong learning disabilities), practical education (*praktijkonderwijs*) is available. Transition support focuses on preparing students for the labour market through practice-based learning, but also on making sure each student obtains a basic qualification. Good collaboration between vocational schools and business/industry has been established through 200 000 companies that are certified to provide practice-based training where vocational students are trained on the work floor as part of their study. This collaboration has been further strengthened when, in 2012, the vocational schools and certified companies developed a foundation (called SBB) to further improve practice-based training. The main targets of SBB are developing agreements on the content of vocational studies and examination, and recording the needs of the labour market so schools can adjust their programmes if necessary. To realise these targets, 17 knowledge centres support SBB and pilot projects are conducted to evaluate initiatives to improve the transition of vulnerable students into the labour market.[4] Two examples of such projects are presented in Box 2.4.

As seen within the area of ESL policy, awareness of the vulnerability of youth with (mild-to-moderate) mental health problems seems to be missing within transition policy. Youth with mental health problems are less likely to be employed than youth without mental health problems. Data from the Netherlands Institute for Social Research (SCP) showed that among youth aged 16 to 24, 73% of those without mental health problems had some form of work compared with only 64% of the youth with mental health problems (Rijksinstituut voor Volksgezondheid en Milieu, 2013). Only those with severe mental disorders who will go on to special education and disability benefits may profit from projects as described in Box 2.4. No activities are in place to support youth with mild-to-moderate mental disorders with their transition into the labour market while they form a clear risk group. For these youth, transition support starting early in life – i.e. at the beginning of the school career, comparable to what is available for youth with more severe problems – is needed (van den Berg et al., 2013).

Box 2.4. **Helping vulnerable students to enter the labour market**

"Boris helps you into work"

The project "Boris helps you into work" (in Dutch: *Boris brengt je naar een baan*) was developed to see how schools in secondary special education could better support students with disabilities in acquiring a job. In collaboration with the SBB knowledge centres, the approach of practice-based learning in certified companies was adapted to students with disabilities in secondary special education. In total, 355 students participated in the project of which 178 have not yet finished the Boris trajectory and 56 dropped out. Of the 121 students who finished the complete Boris trajectory, 51% ended up in work (i.e. a labour contract or entering vocational education with a study-work trajectory), 31% went on to subsequent education and the remaining group moved on to sheltered employment or daytime activities. The participating schools judged that the project helped them in improving the quality of practice-based learning trajectories, acquiring a better view on the job opportunities within the region and extending their network for internships (OCW, 2012).

"With the coach for the job"

The project "With the coach for the job" (in Dutch: *Met de coach naar de job*) was developed to see how students with a disability could be better supported during the internship in their final study year and in their transition into the labour market. Job coaches were placed in secondary special education to help students looking for a suitable company for their internship and to guide them during the period of the internship. Schools with a job coach were compared to schools who did not participate in the project. The results showed that students with a job coach did not finish their internship more often but they had fewer problems during their internship and more often acquired regular work after finishing the study (50% compared with 33% of the students without a job coach; Coenen et al., 2011).

Conclusions and recommendations

The Dutch school environment provides a good support structure for youth struggling with social-emotional, behavioural or learning problems through internal care teams (for lighter and immediate problems) and external care and advice teams (for more complex problems). However, there is not a full coverage of internal and external care teams, especially in primary schools. Notwithstanding the successes of external care and advice teams (e.g. quick mobilisation of help and effective problem management), several problems have been identified, including a lack of preventive actions and the disconnection from the youth care system. These care teams are confronted with very high caseloads and insufficient resources, resulting in an exclusive focus on the students with more severe problems.

The youth care system with its scattered services remains problematic in the Netherlands. Youth care will be decentralised to the municipalities as from 2015. It is unclear, however, whether this will improve co-ordination

and collaboration between the different services. For example, the change in youth legislation in 2005 with the provincial youth care centres as central entrance point for youth care did not result in the foreseen improvement in co-ordination between services. Not in the least because parents and children did not consult the youth care centres but preferred to go to their GP. The same could happen again with the new municipal services.

The past years, the number of early school leavers has shown a fast downward trend in response to several successful policy changes since 2007, implemented to achieve EU targets. Nevertheless, youth with mental health problems have lower educational attainment, higher risks to leave school early and are over-represented in vocational schools where most early school leaving occurs. The vulnerability of these youths needs to be part of policies preventing early school leaving.

Similarly, the exclusive focus on school-to-work transition support for youth with more severe (mental) disorders ignores the fact that youth with mild-to-moderate mental disorders also struggle with finding and retaining work compared with their healthy peers. Although youth unemployment is not as high in the Netherlands as in neighbouring countries, it has been rising over the past years. A more active policy to support youth, and specifically youth with mild-to-moderate mental disorders, in making a successful transition from school to work may help to stop a further increase in youth unemployment.

Finally, the transition support for youth with mild-to-moderate mental disorders should be introduced at the beginning of the school career. A sustainable job is critical since employment leads to an income for living, better health and a purpose in life. In addition, in the Netherlands, the employer's support system to remain in work is much better developed than the employment support provided by governmental institutions when people are out of work, thus increasing the importance of quickly entering the labour market.

Improve school services

- *Ensure full coverage of internal and external care teams for all education levels.* The multidisciplinary care teams are an ideal structure for early identification and support of youth with mental health problems, and all youth should be able to profit from this. Neither internal nor external care teams are obligatory, but the government could stimulate school investment by earmarking part of the school funding for developing and supporting these teams.

- *Invest in preventive mental health programmes in schools.* Internal and external care teams are primarily focused on those students with

more severe problems. Preventive programs focusing on students' coping skills and behaviour, social and emotional learning, resilience and optimism but also on teachers' knowledge and skills on these topics can contribute to mental well-being and early support for milder problems.

Assure successful implementation of the big reforms

- *Train teachers in signalling and dealing with students with mental health problems.* As part of the new act on student centred education more students with mental health problems will be included in regular schools. Schools therefore receive funding to educate their teachers in how to deal with students who have extra support needs. However, teachers also need to be educated in how to assess and address mental health problems in children without over-stigmatising and what they can do before activating additional support. This training should be included in the teaching curriculum.

- *Create visibility of and trust in the municipal structure as entrance to youth care.* The main role of municipalities as entrance point to youth care can only be ensured when parents, children, GPs and other medical specialists trust in the municipalities' ability to perform this role and can easily access municipal services. Municipalities need to communicate the expertise they have to support youth with mental health problems and refer them to adequate care, so that parents will become inclined to visit the municipal centres. Additionally, collaboration between GPs and municipalities is necessary to ensure that GPs refer parents and children to the municipality.

- *Closely monitor the reform of youth care.* The decentralisation of youth care has the potential for better co-ordinated and better integrated care trajectories with the municipalities as case managers. However, municipalities have had little time to ensure proper implementation by the beginning of 2015, and budget cuts might further impact effective implementation. Whether people will really use the municipalities as entrance point to youth care and will receive care better adapted to their needs has to be monitored.

Devote more attention to youth with mild-to-moderate mental disorders

- *Policy on early school leavers needs to specifically address youth with mental health problems.* As youths with mental health problems are at higher risk for early school leaving, the mainstream

school leave policy should address this. For example, more resources (i.e. mental health training) should be provided to the regional register and co-ordination centres for helping these youths back to school. Results of the centres in guiding youth back to school need to be monitored to further improve their services.

- *Develop transition activities for youth with mild-to-moderate mental disorders.* The increasing youth unemployment rate in general and the higher risk of youth with mental health problems to become unemployed ask for an active policy on supporting these youth in their transition into the labour market. For example, job coaches could be installed in secondary, vocational and higher education with specific expertise on the problems that may be encountered by youth with mild-to-moderate mental health problems, such as anxiety about job interviews and how to deal with problems while at work.

Expand transition activities to early (school) life

- *Improve early signalling of mental health problems to provide proper school support.* Whereas learning problems or behavioural problems are more easily identified among children, additional mental health problems such as anxiety or depressive feelings are more difficult to pick up. Schools need to keep a focus on these potential secondary mental health problems and offer additional support services as these problems can gravely impact school success when left untreated.
- *Select an appropriate school that fits the student's level.* For youth with mental disorders, an underestimation of the student's capabilities might occur. Being in special education while having higher capabilities might increase chances of leaving school early. These students could benefit from inclusion in regular education.
- *Invest in family treatment.* A stable family environment is essential for a successful school career and transition into the labour market. However, youth with mental health problems are often additionally confronted with family problems. Providing family treatment might be costly, but in the long-term can contribute to educational attainment and a sustainable transition into work of the children involved.
- *Provide interventions focused on improving social and employee skills.* Youth with mental health problems often lack social and employee skills to acquire a job in the regular labour market. Throughout the school career, training should be provided to improve these skills.

Notes

1. www.passendonderwijs.nl (accessed 28 March 2014).
2. www.passendonderwijs.nl (accessed 28 March 2014).
3. www.ingrado.nl (accessed 28 March 2014).
4. www.s-bb.nl (accessed 28 March 2014).

References

BMC (2009), *Evaluatieonderzoek Wet op de jeugdzorg: Eindrapport* [Evaluative Research Act on Youth Care], BMC advies management, Amersfoort.

CBS (2012), *Jaarboek onderwijs in cijfers 2012* [Yearbook Education in Numbers 2012], Centraal Bureau voor de Statistiek, Den Haag/Heerlen.

Coenen, L. et al. (2011), *Met de coach naar de job: Een evaluatie van de pilot stagejobcoach* [With the Coach for the Job: An Evaluation of the Pilot Internship Job Coach], Research voor Beleid, Zoetermeer.

Fletcher, J. (2008), "Adolescent depression: diagnosis, treatment, and educational attainment", *Health Economics*, Vol. 17, pp. 1215-1235.

Jaycox, L. et al. (2009), "Impact of Teen Depression on Academic, Social, and Physical Functioning", *Pediatrics*, Vol. 124, No. 4, pp. 596-605.

Jeugd en Gezin (2010), *Professionals in het Centrum voor Jeugd en Gezin* [Professionals in the Centre for Youth and Family], Centrum voor Jeugd en Gezin, Den Haag.

Jeugdzorg Nederland (2013), *Branche rapportage jeugdzorg 2011* [Branch Report on Youth Care 2011], Jeugdzorg Nederland, Utrecht.

McLeod, J. and D. Fettes (2007), "Trajectories of Failure: The Educational Careers of Children with Mental Health Problems", *American Journal of Sociology*, Vol. 113, No. 3, pp. 653-701.

OCW (2014), *VSV Verkenner – Zoom in op schooluitval* [Early school leaving explorer – Zooming in on school leaving], Ministerie van Onderwijs, Cultuur en Wetenschap, Den Haag, www.vsvverkenner.nl, (accessed 26 March 2014).

OCW (2013), *Aanpak voortijdig schoolverlaten* [Approach to Early School Leaving], Ministerie van Onderwijs, Cultuur en Wetenschap, Den Haag.

OCW (2012), *Boris brengt je bij 'n baan: Pilotproject tussen special onderwijs, de kenniscentra en de arbeidsmarkt; Eindrapportage* [Boris Helps You into Work: Pilot Project Between Special Education, The Knowledge Centres and The Labour Market: Final Report], Ministerie van Onderwijs, Cultuur en Wetenschap, Den Haag.

OCW (2011a), *Overcoming School Failure, Policies that Work: Background Report for The Netherlands*, Ministerie van Onderwijs, Cultuur en Wetenschap, Den Haag.

OCW (2011b), *Schooluitval voorkomen in Nederland: Speerpunten huidige aanpak en doorkijk naar vervolgbeleid; Resultaat schooljaar 2009-2010 (voorlopige cijfers)* [Preventing School Dropout in The Netherlands: Priorities of the Current Approach and Perspective on Follow-Up Policy; Result for School Year 2009-10 (Preliminary Numbers)], Ministerie van Onderwijs, Cultuur en Wetenschap, Den Haag.

OCW (2007), *Verder leren dan je neus lang is: Invoering kwalificatieplicht per 1 augustus 2007* [Learning Beyond Your Horizon: Introduction of the Qualification Obligation Per 1 August 2007], Ministerie van Onderwijs, Cultuur en Wetenschap, Den Haag.

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

OECD (2013), *OECD Employment Outlook 2013*, OECD Publishing, Paris, http://dx.doi.org/10.1787/empl_outlook-2013-en.

OECD (2012), *Sick on the Job? Myths and Realities about Mental Health and Work*, OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264124523-en.

OECD (2008), *Jobs for Youth: Netherlands*, OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264041295-en.

Pine, D. et al. (1999), "Adolescent Depressive Symptoms as Predictors of Adult Depression: Moodiness or Mood Disorder?", *American Journal of Psychiatry*, Vol. 156, No. 1, pp. 133-135.

Rijksinstituut voor Volksgezondheid en Milieu (2013), *Gezondheid en maatschappelijke participatie: Themarapport Volksgezondheid Toekomst Verkenning 2014* [Health and Social Participation: Theme Report Public Health Future Exploration 2014], Rijksinstituut voor Volksgezondheid en Milieu, Bilthoven.

Slee, P. et al. (2009). *KidsMatter Primary Evaluation Final Report*, Centre for Analysis of Educational Futures, Flinders University of South Australia.

Statistics Netherlands (2014a), "Speciale scholen; leerlingen, schooltype, leeftijd" [Special schools; students, school type, age], Statistics Netherlands, Den Haag/Heerlen, http://statline.cbs.nl/StatWeb/publication/?DM=SLNL&PA=37746SOL&D1=0&D2=0-45&D3=a&D4=12,l&HDR=T,G3,G2&STB=G1&VW=T (accessed 28 March 2014).

Statistics Netherlands (2014b), "Personen met of zonder startkwalificatie voor de arbeidsmarkt" [Persons with or without a basic qualification for the labour market], Statistics Netherlands, Den Haag/Heerlen, http://statline.cbs.nl/StatWeb/publication/?DM=SLNL&PA=80171NED&D1=0&D2=1&D3=1&D4=17-24,29-39&D5=0,10-11&HDR=T,G4&STB=G1,G2,G3&VW=T (accessed 28 March 2014).

Traag, T., O. Marie, and R. van der Velden (2010), "Risicofactoren voor voortijdig schoolverlaten en jeugdcriminaliteit" [Risk factors for early school leaving and youth delinquency], *Bevolkingstrends, 2e kwartaal 2010*, pp. 55-60.

Trimbos-instituut (2010), *Trendrapportage GGZ 2010, Deel 2: Toegang en zorggebruik* [Trend Report Mental Health Care 2010, Par 2: Access and Use of Care], Trimbos-instituut, Utrecht.

van den Berg, B. et al. (2013), "Ondersteuning van jongeren met een LVB: Onderzoek naar doeltreffendere en goedkopere ondersteuning gericht op arbeidsparticipatie" [Supporting youth with a mild intellectual disorder: research into more effective and efficient support aimed at labour market participation]; Eindrapport, Regioplan, Amsterdam.

van der Steenhoven, P. and D. van Veen (2012), *Monitor deelnemerszorg en ZAT's in het middelbaar beroepsonderwijs 2011* [Monitoring Student Care and Care and Advice Teams in Vocational Education 2011], Nederlands Jeugdinstituut, Utrecht.

van der Steenhoven, P. and D. van Veen (2011a), *Monitor ZAT's, zorgteams en leerlingenzorg in het primair onderwijs 2010* [Monitoring Care and Advice teams, Care Teams and Student Care in Primary Education 2010], Nederlands Jeugdinstituut, Utrecht.

van der Steenhoven, P. and D. van Veen (2011b), *Monitor leerlingenzorg en ZAT's in het voortgezet onderwijs 2010* [Monitoring Student Care and Care and Advice Teams in Secondary Education 2010], Nederlands Jeugdinstituut, Utrecht.

van Gastel, M. (2012), "Gemeenten aan zet: Twee wegen naar de GGZ voor zorggezinnen" [Municipalities at play: two ways to mental health care for families needing care], Algemene Bestuurdienst Tijdelijke Opdrachten, Projecten en Programma's, Den Haag.

Veldman, K. et al. (2014), "Mental Health Problems and Educational Attainment in Adolescence: 9-year Follow-up of the TRAILS Study", *PLoS One,* Vol. 9, No. 7, pp. 1-7.

VWS (2012), "Voortgangsbrief stelselwijziging jeugd 'Geen kind buiten spel'" [Letter on progression in youth system change 'No child on the sideline'], Ministerie van Volksgezondheid, Welzijn en Sport, Den Haag.

VWS and VJ (2013), "Stelselwijziging Jeugd: Hoofdlijnen wetsvoorstel Jeugdwet" [Youth System change: main features of the legislative proposal Youth Act], Ministerie van Volksgezondheid, Welzijn en Sport and Ministerie van Veiligheid en Justititie, Den Haag.

Chapter 3

Working conditions and sickness management in the Netherlands

This chapter looks at the role of the workplace, which provides an ideal setting for interventions to help people in the workforce deal with mental health problems and retain their jobs. It first describes the link between working conditions and mental ill-health, reduced productivity and sick leave. Then the chapter discusses prevention policies to address psychosocial risks at work as well as sickness management strategies of Dutch companies. The chapter ends with a review of the central role of employers and occupational physicians in case of sickness absence.

There is increasing evidence that employment has positive effects on people's mental health by providing a social status, income security, a time structure and a sense of identity and achievement. Yet, poor quality jobs or a psychologically unhealthy work climate can erode mental health and, in turn, lead to a more precarious labour market situation. Therefore, the working environment is a key target for improving and sustaining labour market inclusion of those with mental illness, and fast action in case of sickness absence is critical.

Working conditions and mental ill-health

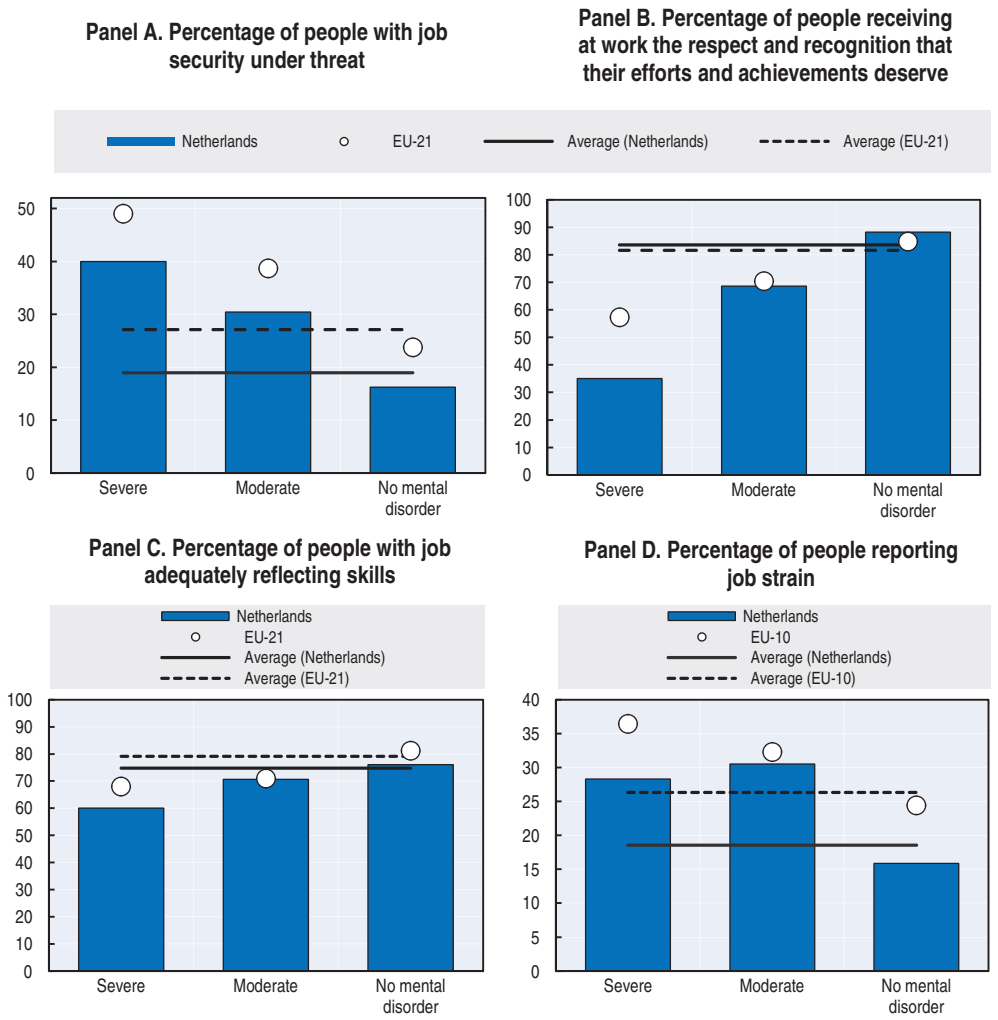
Based on the evidence available for a range of OECD countries, the OECD's report on mental health and work, *Sick on the Job?* (OECD, 2012) concluded that: i) workers with a mental disorder perceive their jobs as qualitatively poor; ii) job strain can have a significant negative impact on the worker's mental health; iii) self-reported job strain has increased in most occupations over time; and iv) good management is one of the key factors in assuring quality employment and mitigating workplace mental health risks.

Data for the Netherlands are in line with these findings even though some working conditions seem to be slightly better than those in other countries. Like elsewhere, people with severe or moderate mental disorders more often report job insecurity (Figure 3.1, Panel A), less often receive the recognition and respect at work they deserve (Panel B) and a lower share among them has a job which adequately reflects their skills (Panel C). People with a mental disorder are also much more likely to report job strain, i.e. to work in jobs that are psychologically demanding but leaving limited decision latitude (Panel D). The differences by degree of severity of the mental disorder are large, except with respect to job strain, where people with a severe mental disorder are as likely to report job strain as those with a more moderate mental disorder. Overall, the level of job strain and job insecurity (for all workers) is lower in the Netherlands than on average across EU countries.

Simple associations between working conditions and the mental health status do not prove causality, however, and could instead illustrate that workers with poor mental health are less likely to find good-quality jobs or perceive their working conditions to be of poorer quality. Nevertheless, extensive academic literature on this topic (see the meta-analysis by Stansfeld and Candy, 2006) provides consistent evidence for the causal effects of high job strain and other working characteristics on mental health.

Figure 3.1. **Workers with a mental disorder work in jobs of slightly poorer quality**

Selected job-quality indicators for workers with a severe, moderate or no mental disorder, in the Netherlands and on average over 21 European OECD countries in 2010



Source: OECD calculations based on Eurobarometer 2010, except Panel D based on *European Working Conditions Survey 2010*.

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Preventing psychosocial risks at work

Employers are legally obliged through the Labour Conditions Law (so-called "Arbo Law") to: i) perform an assessment of all risk factors the firm faces in the field of occupational safety and health, including psychosocial risks at work (such as stress at work as a consequence of work pressure, aggression and violence, sexual harassment, bullying and discrimination); ii) set up an action plan to address existing risk factors; and iii) develop a sickness management policy (see next section for the latter). Employers are also required to inform their employees about psychosocial risk factors, as well as the measures undertaken to prevent or reduce them. However, the Arbo Law does not give explicit instructions on how to deal with the health requirements mandated by law and it is left at the interpretation of the employers and employees how to identify and evaluate working conditions and stress at work.

As part of their occupational health and safety policy, companies are obliged to appoint a prevention specialist and a certified Arbo specialist or an occupational physician:

- The *prevention specialist* is responsible for the health and safety at work and is internally appointed. They assist the company in carrying out the risk assessment and setting up the action plan. In companies with less than 25 employees, the employer is allowed to be the prevention specialist.[1]
- The *Arbo specialist* is either hired from a certified Arbo service[2] or organised independently by the company (the latter option is allowed since 2005, but only on the condition that it is approved by the board or employees' representation). The Arbo specialist can be an occupational physician, an occupational hygienist, a safety professional or a labour and organisational specialist. They control the risk assessment and action plan of the company, and assist the company in its sickness management strategy (see below). Companies with less than 25 employees are not obliged to have their risk assessment tested by an Arbo specialist on the condition that they use a certified risk assessment instrument.
- The *occupational physician* can be employed by an Arbo service or work on an independent basis. Occupational physicians assist the company in its sickness management and are responsible for the reintegration of workers on long-term sick leave.

Data from the Dutch Labour Inspectorate allow a closer look at the compliance with the labour legislation by Dutch companies.[3] Overall, just half of all companies effectively implement the policies requested by the Arbo Law but compliance has been declining since 2006 (Table 3.1). In 2010, merely 45% of the companies in the Netherlands dispose over a risk assessment, of which one third is not even tested. Compliance is better among companies with more than 25 employees (data from Statistics Netherlands show that firms with more than 20 employees provide about 78% of all available jobs in the Netherlands), but even among this group, 14% does not have a risk assessment and 15% does not have their assessment controlled by a certified Arbo specialist as requested by law. In addition, about one third of the risk assessments that have been undertaken fail to address all risk factors faced by the firm (Arbeidsinspectie, 2011). Similar results hold for the obligation to have an action plan to address risk factors, as well as for the requirement to appoint a prevention specialist – respectively 38% and 43% of all companies do so. On a positive note, most companies do contract an Arbo specialist and consult their employees about their Arbo policy, with nearly full compliance among larger companies.

Table 3.1. **About half of the Dutch companies do not comply with the labour law**

Percentage of firms complying with the labour legislation, 2006 and 2010

	2006	2010			
	Total	Total	≤25 employees	>25 employees	
Risk assessment	50	45	41	86	
Tested risk assessment	36	31	27	71	
Non-tested risk assessment	14	14	14	15	
		Total	<10 employees	10-99 employees	≥100 employees
Action plan	43	38	30	65	89
Prevention specialist	53	43	36	66	93
Arbo specialist	87	76	71	95	100
Consultation with employees	-	96	96	95	99
Information and education of employees	-	61	57	78	94
Sickness management policy	79	71	65	95	100
Arbo catalogue[a]	1	11	9	20	46
Number of firms in the Netherlands		1 124 095	1 060 685	55 935	7 475
Percentage of total			94.4%	5.0%	0.7%

a. Data refer to 2007 instead of 2006.

Source: Based on Arbeidsinspectie (2011), *Arbo in Bedrijf 2010* [Health and safety at work 2010], Ministerie van Sociale Zaken en Werkgelegenheid, Den Haag.

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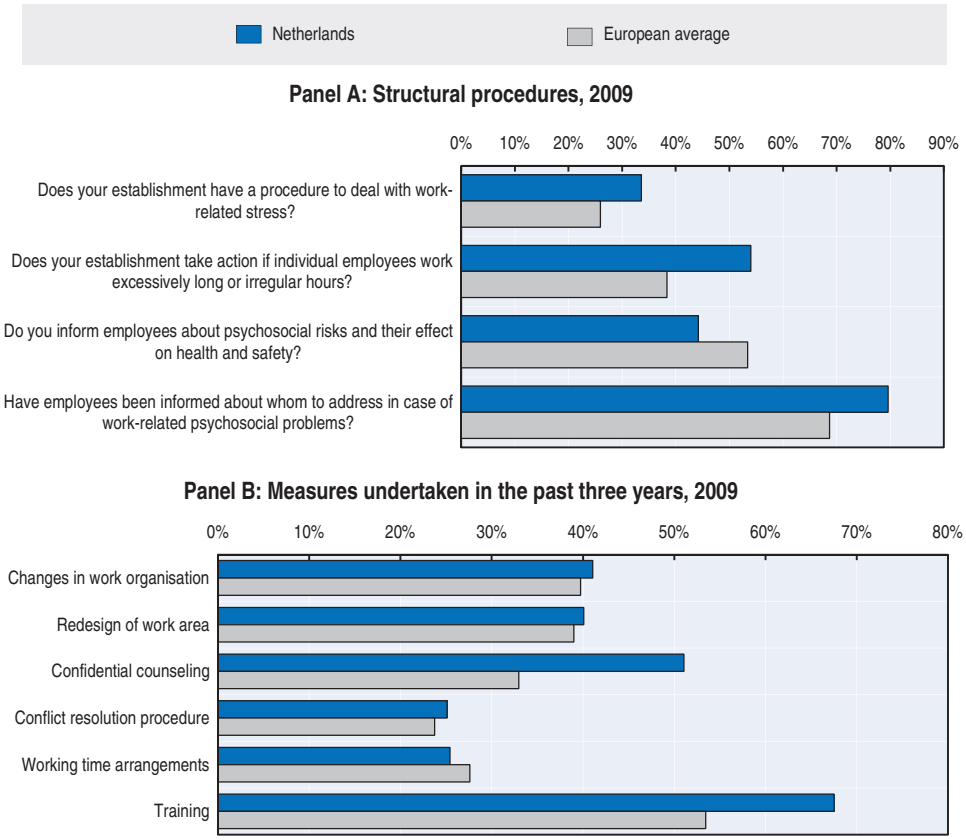
Companies who do not comply with the labour law can be sanctioned by the Labour Inspectorate. The amount of the sanction depends on the number of employees in the company and the severity and repetition of the infraction. In 2012, about one percentage of the firms in the Netherlands was inspected for compliance with the Arbo Law and in 63% of the cases the companies were sent a warning, sanctioned or even closed down (Inspectie SZW, 2012). The Social and Economic Council of the Netherlands expressed its concern about the low inspection frequency by the Labour Inspectorate, as it might have a negative effect on labour law compliance by companies. The Council advised the Dutch Government to assure sufficient pressure on companies. For example, digital risk assessments, instead of pen-and-paper assessments, would make it easier for companies to conduct a risk assessment and could increase labour law compliance (SER, 2012).

Social partners can make agreements at the branch or sector level about how to fulfil the legal requirements of the Arbo Law through Arbo catalogues. These catalogues are not obligatory for companies in the sector, but provide guidelines to implement an Arbo policy. In April 2013, there were 164 such Arbo catalogues approved by the labour inspectorate.[4] Even so, according to the 2012 Netherlands Employers Work Survey (NEWS), many employers (45%) do not know whether such catalogue exists in their branch or sector, and even if they do know about the catalogue (22% of the employers), about one fifth of them would not use it (Oeij et al., 2013). The limited use of the catalogues is confirmed by data from the Dutch Labour Inspectorate, according to which only 11% of Dutch companies make use of an Arbo catalogue (Table 3.1). While the catalogues would be particularly useful for small enterprises which do generally not have specialised staff to develop their own policy, the use of Arbo catalogues is much more limited among companies with less than 10 employees (9%) than among companies with more than 100 employees (46%).

In comparison with companies in other European countries, Dutch companies tend to devote more attention to the management of psychosocial risks at work. A survey conducted by the European Agency for Safety and Health at Work (2010) illustrates that one in three Dutch companies have a procedure to deal with work-related stress, compared with one in four companies in Europe on average (Figure 3.2, Panel A). Dutch companies are also more likely than European companies to undertake action when an employee works excessively long or irregular hours and to inform their employees about whom to address in case of work-related psychosocial problems. With respect to individual measures – such as changes in the work organisation and area, confidential counselling, conflict resolution and the provision of training – Dutch companies score (slightly) better than their European counterparts (Figure 3.2, Panel B). Yet, they are less likely to

inform their employees about psychosocial risks at work and their effect on health, in part due to the stigma attached to psychosocial problems (Hooftman et al., 2012).

Figure 3.2. **Dutch companies devote more attention to the management of psychosocial risks than companies in other European countries**



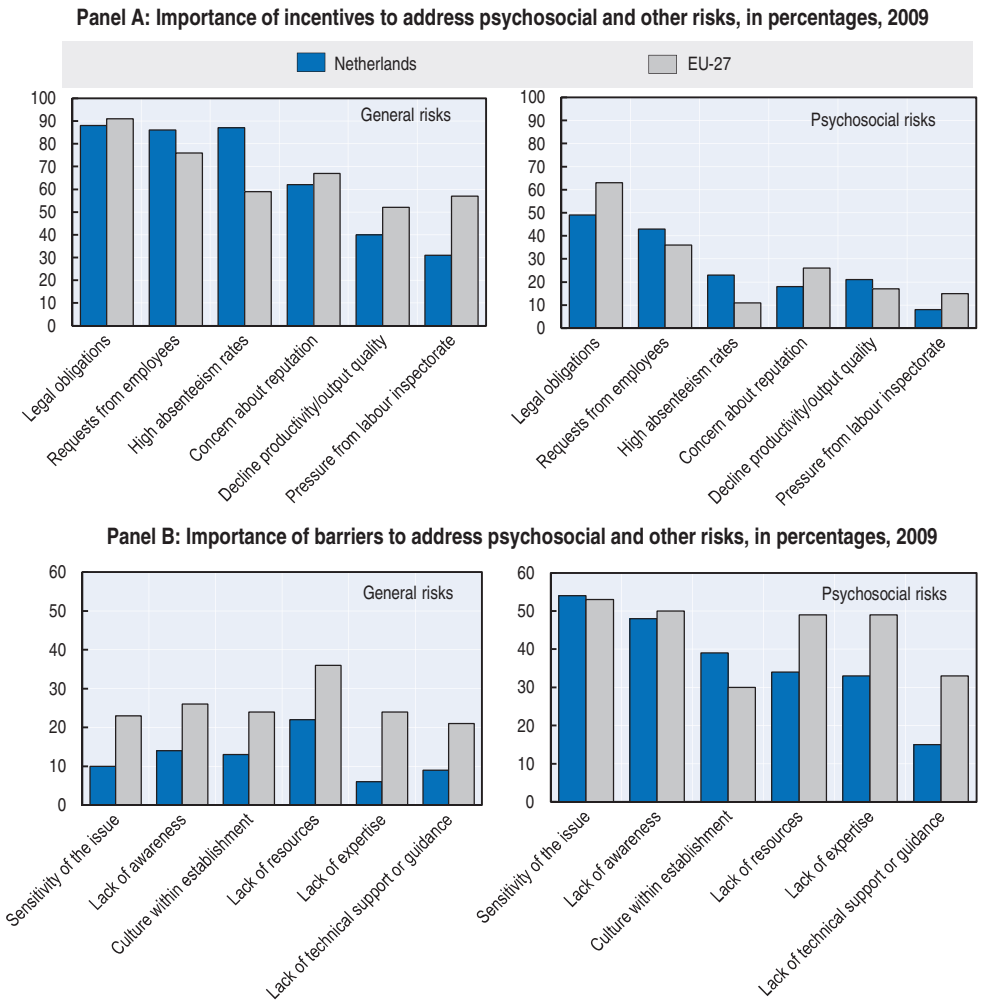
Source: OECD compilation based on the *2009 European Survey of Enterprises on New and Emerging Risks (ESENER)* of the European Agency for Safety and Health at Work; https://osha.europa.eu/sub/esener/en.

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According to the same survey, the main reasons for addressing risk factors at work are legal obligations, high absenteeism rates and pressure from employee representatives (Figure 3.3, Panel A). Surprisingly, these factors play a much smaller role in encouraging employers to address psychosocial risk factors at work than risks in general, both in the Netherlands as in other

European countries. While 87% of the Dutch companies confirm that high sickness absence is an important reason for investing in preventive measures, only 23% would address psychosocial risk factors – the percentages in the EU on average are 59% and 11% respectively.

Figure 3.3. **Incentives to address psychosocial risks are low, while barriers are high**



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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Sensitivity of the issue, lack of awareness, lack of resources, culture and lack of expertise are given as major impediments for the execution of a preventive policy in the field of psychosocial risks (Figure 3.2, Panel B). Despite legal obligations and strong financial incentives in the Netherlands, the barriers are as important in Dutch companies as in other European companies, with the exception of expertise, knowledge and guidance, which seem to be less of an obstacle in the Netherlands.

From the point of view of employees, there is room for improvement in the stress management of Dutch companies. According to data from the National Survey of Working Conditions 2011,[5] three out of ten employees complain about insufficient measures against work pressure and stress. A recent evaluation by Bakker et al. (2011) also shows that interventions in companies are mainly targeted at individual problems while they hardly focus on the organisational aspects of the causes of stress in the company, such as the management style, rules and opportunity for development.

Between 2014 and 2018, the Ministry of Social Affairs and Employment is implementing an action programme to tackle psychosocial work demands (e.g. work pressure, and aggression, bullying and sexual harassment at work). The programme is aimed, first, at breaking the taboo of talking about psychosocial work demands and putting this topic on the agenda, and, second, at facilitating and stimulating stakeholders to actively tackle psychosocial work demands to prevent sickness absence and increase resilience, work engagement and productivity. To realise this, activities are planned to: i) increase awareness of psychosocial work demands; ii) stimulate companies to create a culture of open dialogue between employees and supervisors on psychosocial work demands and, this way, increase early action; iii) develop a business case showing the return-on-investment of tackling psychosocial work demands; and iv) provide available knowledge and instruments for employers and employees. This action programme is part of the Ministry's larger programme on improving workers' sustainable employability (SZW, 2013a).

Effective sickness management at the workplace

To secure good working conditions to prevent workers from being worn out by work emotionally and mentally is one side of the coin. The other side is to tackle mental health issues when they arise – be they caused by, related to or unrelated to work – and to limit their implications on the worker's performance. As workers with long-term sickness absence have a six times higher disability risk, early sickness management and return-to-work programmes are crucial (Koopmans et al., 2008). Research has also shown

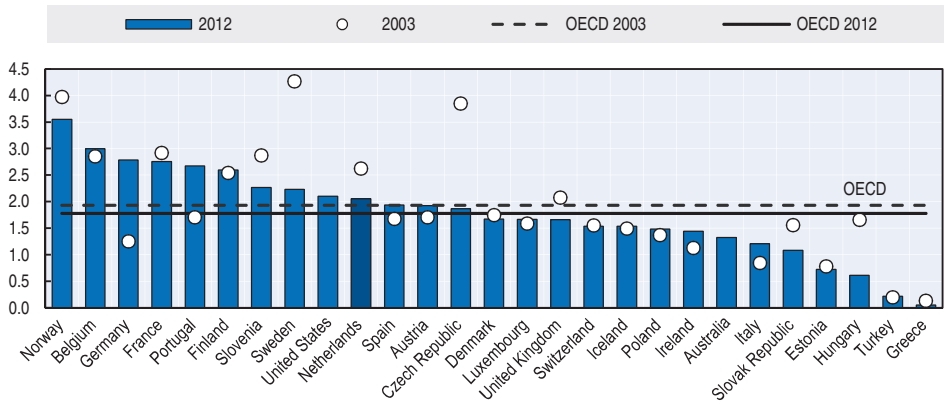
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that collaboration from the employer is particularly important to enable sustainable return to work (Oomens et al., 2009; Noordik et al., 2011).

Since the 1990's, several policy changes have been introduced in the Netherlands to reduce sickness absence from its unsustainable levels in the 1990's (SCP, 2012). In particular, the Act on Reducing Absenteeism (1994), the Act on Extension of Wage Payment during Sickness (1996 and extension in 2004) and the Gatekeeper Improvement Act (2002) contributed to significant improvements in sickness management (van Sonsbeek, 2011).[6] Between 2003 and 2012, the sickness absence rate in the Netherlands dropped from 2.6 to 2.1%, but it remains above the OECD average of 1.8% (Figure 3.4).

Figure 3.4. **Sickness absence in the Netherlands dropped considerably but remains above the OECD average**

Incidence of sickness absence of employees in selected OECD countries, 2003-12[a, b]



Note: The incidence of work absence due to sickness is defined as the share of employees absent from work due to sickness and temporary disability (either one or all days of the work week). Data are annual averages of quarterly estimates. Estimates for Australia and Canada are for full-week absences only.

a. Data for 2003 refer to 2005 for Estonia and 2006 for Turkey. Data for 2012 refer to 2004 for Australia.

b. OECD is the unweighted average of the countries shown in the chart.

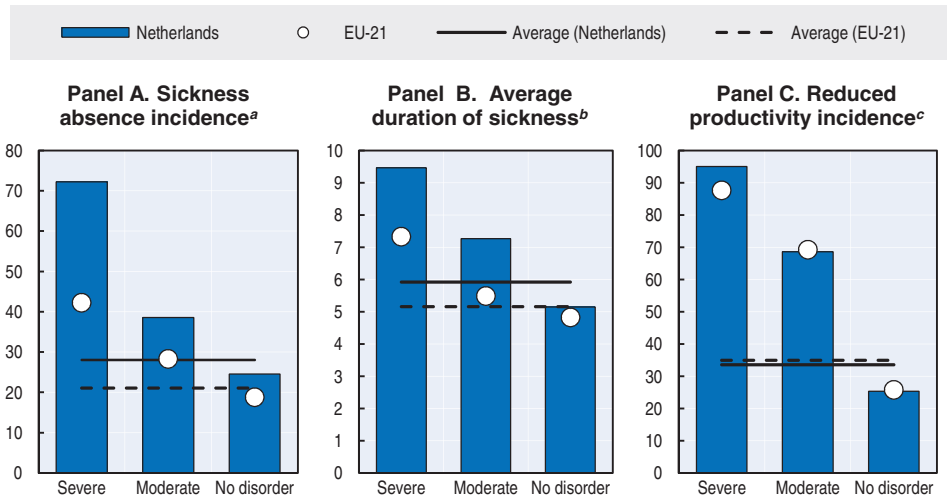
Source: OECD absence database, based on *European Union Labour Force Survey (EULFS)* for European countries and *National Labour Force Surveys* for Australia and the United States.

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While sickness management has been considerably improved in the Netherlands, sickness absence due to poor mental health remains high. Compared with other EU countries, the percentage of people with moderate or severe mental health problems who are absent from work is about one-third to double as high in the Netherlands (Figure 3.5, Panel A). Mental health problems are also an important contributor to the total amount of sickness absence costs (Steenbeek et al., 2010; de Graaf et al., 2012). Moreover, sustainable return-to-work and at-work performance of workers with mental health problems remain a challenge. Koopmans et al. (2011) found that 20% of the workers who return to work after sickness absence due to mental health problems experience recurrent sickness absence. Regarding at-work performance, Steenbeek et al. (2010) showed that of all chronic disabilities, workers with mental disorders most often reported performance problems at work, which is in line with the data presented in Figure 3.5, Panel C.

Figure 3.5. **Sickness absence and reduced productivity both increase sharply with poorer mental health**

Incidence of sickness absence and reduced productivity (in percentage) and average absence duration (in days), by mental health status, in the Netherlands and on average over 21 European OECD countries in 2010



a. Percentage of persons who have been absent from work in the past four weeks (apart from holidays)

b. Average number of days absent from work in the past four weeks (of those who have been absent).

c. Percentage of workers not absent in the past four weeks but who accomplished less than they would like as a result of an emotional or physical health problem.

Source: OECD calculations based on Eurobarometer, 2010.

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The following sections focus on how sickness management is arranged in the Netherlands and what the roles of the employer, the occupational physician and other health care providers are in return-to-work management.

The employer has the primary role in sickness management

When a worker becomes sick, the employer is obliged to continue paying 70% of the salary for two years.[7] During these two years, sick workers are protected by law against lay-off and contrary to all other OECD countries, no differentiation is made between work-related sickness absence and non-occupational sickness absence. Also, the worker does not need a sickness certificate from their general practitioner to validate the right to continued wage payment contrary to most other countries.

With the Gatekeeper Improvement Act (2002), the Dutch Government enforced employers and workers to take up their responsibility with respect to sickness management. In particular, the employer needs to install a return-to-work case manager who guards the return-to-work process. Within six weeks of sickness absence, the employee needs to visit an occupational physician (OP), who is paid by the employer. Within eight weeks of absence, the employer and the employee are obliged to agree on an action plan, which describes the responsibilities of both the employer and worker for ensuring a quick return to work. During the entire sickness absence period, the employer is responsible for monitoring the return-to-work process every six weeks and for recording all actions undertaken (this is often done by the return-to-work case manager). The employer is not allowed to ask about the medical reasons for sickness absence but can discuss the return-to-work process with the employee and OP.

Both the employer and worker can be penalised for not collaborating in the return-to-work process, which is being judged by the Employee Insurance Agency after two years of sickness absence. If employers did not sufficiently collaborate in return-to-work activities, they have to pay the worker's salary for a third year of sickness absence. Non-collaboration from the side of the worker (e.g. not accepting a different job below their educational level after one year of sickness absence) is penalised by a stop in salary payment or layoff – this can happen at any time during the first two years of sickness absence – or reduced disability benefits after two years.

If the employer cannot provide adjusted work necessary for a sick worker to be able to return to work, both the employer and the worker are obliged to look for suitable work with another employer. The type of work that is deemed suitable depends on the worker's capacities, educational level and work experience, but also on the length of sickness absence. Until the first half year of sickness absence, a job in a different company should fit

the worker's capacities, educational level and work experience. After this period, work below the worker's educational level is deemed suitable and has to be accepted by the worker. The longer the worker is on sickness absence, the more jobs are considered appropriate.

Finding suitable work with a different employer can be facilitated by occupational health care services, reintegration offices and employer branch organisations. Some branch organisations have a database with job vacancies within the branch or developed small-scale networks to exchange workers (SZW, 2013b).[8] A small survey in 2007 among employers with an employee who had been sick for at least nine months revealed that 48% of the employers tried to reintegrate their sick employee in another company, often in co-operation with a reintegration office (van de Burg et al., 2010). When a new employer is found, the worker will first work on a secondment contract and continues to be paid by the initial employer for an agreed period of time. After this period, and if all parties are satisfied, the worker receives a contract with the new employer with full obligations for the new employer.

Some companies have, in addition to the return-to-work case manager, also a social worker who provides support in dealing with psychosocial problems that impact work.[9] For instance, the social worker can start short treatment sessions aimed at coping, behavioural change and empowerment; refer to other health care professionals; mediate work conflicts; advise and train management/supervisors about sickness management; and act as a confidant in case of harassment (NVMW, 2009). The social worker only focuses on the work context, however, and does not provide support in other life areas (e.g. money management) which would fall under the responsibility of regular social workers.

Data show that not all employers live up to their responsibilities for return-to-work management as stated by law. Regarding the obligation to contact an OP in case of sickness absence within the first six weeks, 50% of the employers responded that they did not have any guidelines for when to contact the OP, and 1% responded that this was not done within the first six weeks. Follow-up by the government on employers who do not fulfil the legal obligations regarding sickness policy is limited. Employer activities are only evaluated if a worker has more than 90 weeks of sickness absence because then the case is judged by the Employee Insurance Agency (UWV), which is the governmental body that can penalise employers for not having invested in return to work. As example, in 2012, UWV reported that in 19% of sickness absence cases longer than two years the employer received a sanction, i.e. a third year of wage payment (UWV, 2012). Common reasons for employer penalties are not having participated in finding suitable work for the sick worker at another employer (in 24% of the cases) and lack of any reintegration activities (in 23% of the cases) (de Jong et al., 2011). In

comparison, sanctions for the worker are rare, accounting for only 3% of all sanctions (de Jong et al., 2011). This low percentage is probably due to the fact that during the two-year reintegration process employers already have the opportunity to sanction the worker for non-collaboration (e.g. by a stop in wage payment or lay-off).

Occupational physicians role in sickness management

Occupational physicians are well installed in the Netherlands as the law states that employers need to consult an OP in sickness management. Most OPs are employed by an occupational health service, but they can also work independently. An important role of the OP is to make the problem analysis and advise on a reintegration action plan (people typically resume work in a gradual way, see Box 3.1) within six weeks of sickness absence. The OP is also responsible for writing a reintegration report for the Employee Insurance Agency after the 90th week of sickness absence. To manage sickness absence of workers with mental disorders in particular, there is an evidence-based (i.e. scientifically proven effective) guideline for OPs from the Netherlands Organisation of Occupational Medicine, with detailed advice about how to guide workers with mental health problems back to work, referrals to secondary care and contact with the employee's general practitioner (see Box 3.2). However, research has shown that adherence is limited (Rebergen et al., 2006; Rebergen et al., 2010; Nieuwenhuijsen et al., 2003).

Box 3.1. **Gradual return-to-work in the Netherlands**

Within the Dutch occupational health sector, it is well accepted that work contributes to health and that long absenteeism from work increases the risk of work disability. It is common practice for OPs to have sick workers start with partial work resumption and to gradually build-up working hours. For example, data of Arends et al. (2013) show that within a group of 158 workers on sickness absence due to mental health problems, the percentage of working hours at the start of return-to-work was 40% on average. Three, six and twelve months after returning to work the percentage of working hours were on average 76%, 86% and 91%, respectively (unpublished data). Although gradual return-to-work is common, there is no evidence-based knowledge on how gradual the process should be build-up to enable sustainable reintegration for workers with mental health problems. Possibly, different gradual return-to-work plans might be more effective for mild versus more severe mental disorders. Currently, OPs (or other case managers) decide themselves how gradual the return to work is built-up and the process can be very different for workers with comparable mental health problems.

Since 2005, OPs are no longer exclusively responsible for monitoring the reintegration process. Although it remains obligatory that an OP conducts the problem analysis and writes the reintegration report, employers have been given the freedom to organise return-to-work support within the company, for instance by human resource managers or the employee's supervisor. Thus, any kind of return-to-work case manager can be installed and no professional profile exists for these case managers (NVAB, 2013). This has resulted in decreased evidence-based sickness management (e.g. return-to-work case managers are not necessarily aware of the OP guideline on managing sickness absence of workers with mental health problems) and uniformity across cases, and OPs often complain that they are called in too late to properly perform their work (de Zwart et al., 2011). Additionally, the privacy of sick employees (i.e. keeping medical information secret) is harmed more easily by internal return-to-work case managers as they do not work under a medical oath (de Zwart et al., 2011).

Box 3.2. **Guideline on the management of mental health problems among workers by occupational physicians**

The guideline proposes that sickness absence due to mental health problems is the result of the inability to cope successfully with daily (work) stressors which results in a feeling of loss of control and distress. Therefore, treatment by OPs should focus on helping the worker to regain control. The treatment to enable a return to work consists of three phases. The first phase is focused on providing a rationale for why sickness absence occurred, educating the worker about future prospects and structuring daily life. In the second phase, problems are addressed that caused sickness absence and the worker is stimulated to generate solutions to return to work. In the final phase, gradual return-to-work is started and the solutions to problems are implemented. For each phase, the guideline describes different interventions that can be applied by the OP. At least one consultation is recommended to take place after the reintegration to address relapse prevention (NVAB, 2007).

The position of the OP is further threatened by the declining number of active OPs due to a decreasing number of medical students choosing to specialise as OP (Capaciteitsorgaan, 2013). This could partly be solved by the employers' freedom to select other return-to-work case managers for sickness management, but without a proper professional profile for these case managers, including occupational health expertise, proper sickness management cannot be guaranteed.

The role of OPs is exclusively focused on sickness management with little opportunity for preventive actions (de Zwart et al., 2011; SER, 2012). Before 2007, employers were still obliged to provide their workers with a freely accessible consultation with the OP to talk about their concerns

related to health and work (regardless of sickness absence), but this has been dismissed by the government since 2007. As a result, only 19% of all employers still offer this preventive consultation (Arbeidsinspectie, 2011). Since the pay-off of preventive actions is difficult to translate into direct monetary benefits, preventive actions are seldom part of an employer's contract with the occupational health service.

Neutrality of the OP is often challenged in the Netherlands, as the employer pays for their services (van der Helm, 2013). Research on the OP's position was conducted in 2011 among 541 OPs and 220 workers who had been treated by an OP in the past year (de Zwart et al., 2011). Results showed that 21% of the OPs were not able to conduct their work independently due to interference by the employer. For example, employers sometimes pressure the OP to provide medical information. When return-to-work case managers were responsible for return to work, 56% of the OPs experienced that they were involved too late and had limited possibilities to perform their work according to their professional guidelines. Also, 52% of the OPs argued that workers do not trust the neutral position of the OP. Among the surveyed workers, 29% felt that the OP defended the interests of the employer rather than their own and 10% had held back information because they were afraid it would negatively impact their job (de Zwart et al., 2011).

Co-operation and co-ordination between health care providers is insufficient

General Practitioners (GPs) and psychologists play a limited role in sickness management. An employee does not need a sickness certificate from their GP and it is the role of the OP to advice on return to work, while psychologists in primary and secondary care do not address work issues of their clients.

Communication and co-operation between OPs, GPs and psychologists remains problematic despite specific guidelines. For example, Rebergen et al. (2010) showed that only 7% of the OPs have contact with their clients' GPs. OPs do refer employees to psychologists (46% of employees on sickness absence due to mental health problems were referred to psychological treatment within one year; Rebergen et al., 2010), but there is no or only minimal feedback between the two professions about the treatment process. Even so, each profession has its own guidelines on the treatment of patients with mental health problems in which advice on co-ordination with the other professions is provided (NVAB, 2007). In 2005, a collaborative agreement for OPs and GPs was published on the treatment of adjustment disorders (Romeijnders et al., 2005), and in 2011, a multidisciplinary guideline on the treatment of adjustment disorders and burnout for GPs, OPs and primary care psychologists was published

(LVE, NHG and NVAB, 2011). However, professionals indicate that they are not sufficiently familiar with these guidelines, especially the multidisciplinary guidelines, and co-ordination remains insufficient (Batenburg et al., 2012).

The lack of communication between the medical stakeholders can be problematic in co-ordinating care for the employee. For example, GPs and psychologists pay limited attention to the work conditions of their patients through which they can miss work-related problems that need referral to the OP. Since people first visit their GP while it can take up to six weeks before an employee sees the OP, the role of primary care professionals in recognising work-related problems is particularly important. At the same time, referring an employee to the OP is difficult since employers determine whether and when a consultation with the OP will take place. As another example, GPs and OPs may set different diagnoses and start different treatment plans for the same patient (Batenburg et al., 2012).

Sickness benefit payments are very generous

Compared with most other OECD countries, sickness benefit payments are very generous in the Netherlands with a 70% wage replacement for two years, in most cases topped up to 100% in the first year (Table 3.2). Employers are allowed to install two waiting days where no sickness benefits need to be paid to prevent short-term sickness absence. In practice, this is only being done in specific (often low-paid) employment sectors on the basis of an agreement between the social partners.

The high benefit payment levels could increase *moral hazard* among sickness beneficiaries in the Netherlands. Moral hazard refers to decreased investment in staying at work, returning to work or finding a new job due to high benefit levels, thus increasing the incidence and duration of sickness absence. Several international studies have concluded that an increase in sickness benefit levels resulted in an increase of sickness absences, and the other way around, a decrease in benefit levels resulted in a decrease of sick leave (Johansson and Palme, 2004; Hesselius and Persson, 2007; Markussen et al., 2012). Lowering the relatively high benefit payment levels in the Netherlands might encourage employees to shorten the duration of their sick leave or to stay at work longer. However, important to note is that an earlier return to work per se may not have the best long-term consequences. Financial incentives to return to work quickly or find a job may result in accepting poor working conditions (Koletsi et al., 2009), which could in turn cause (mental) health problems and repeated sickness absence on the long run. The challenge is to find the right balance between return-to-work incentives and income security in periods of sickness absence.

Table 3.2. **The Netherlands has a generous sickness benefit system**

Duration and level of sickness benefit payments across OECD countries, 2014

		Duration of benefits		
		Less than six months	*Six to less than 12 months*	*One year or more*
Benefit replacement rate	<50%	Korea (none), New Zealand, United States (if any)	United Kingdom	Australia, Greece, Ireland
	50-64%	Canada	Belgium, Denmark, Slovak Republic	Austria, Czech Republic, Hungary, Greece, France, Mexico
	65-79%		Estonia, Finland, Italy	Germany, Japan, Portugal
	80-99%	Poland	Sweden, Switzerland	Netherlands, Slovenia
	100%		Luxembourg, Norway	

Source: OECD compilation based on Mutual Information System on Social Protection (MISSOC) data, www.missoc.org (accessed 15 September 2014).

StatLink http://dx.doi.org/10.1787/888933145663

Conclusions and recommendations

Working conditions in the Netherlands are better than on average in the OECD but productivity losses and sickness absence among people with mental health problems remain high. While employers are legally obliged to undertake actions to prevent psychosocial risks at work, the implementation of the labour law is far from optimal, especially among smaller companies. Technical support and knowledge on preventing psychosocial risks at work is widely available in the Netherlands, but stigma and lack of awareness continue to be important barriers. To tackle this, the planned action programme on "psychosocial work demands" from the Ministry of Social Affairs and Employment is a promising step if able to be delivered on a large scale.

The Dutch sickness management system puts the full responsibility for reintegration during the first two years of sickness absence on the employer and employee, an approach that has proven to be successful in reducing sickness absence and new claims for disability benefits. However, compared

with other OECD countries, the sickness absence rate among employees with mental ill-health remains relatively high. A reason may be the generous benefit payment levels, which increase moral hazard problems among sickness beneficiaries. On the other hand, lowering benefit levels might result in returning to work too early and creating more health problems in the long run. In addition, the Dutch benefit system reforms stimulated a narrow focus by employers on return to work to reduce direct sickness absence costs with limited attention for prevention, at-work performance and sustainable reintegration.

Over the years, employers have been given more freedom to organise the reintegration process, which minimised the previously strong role of occupational physicians (OPs) and resulted in reduced specialised knowledge within companies on occupational health and reintegration issues. Moreover, OPs struggle to conduct their work in line with their professional responsibilities, i.e. keeping patient information confidential and staying neutral, as they are hired and paid by the employer.

Communication and collaboration between OPs, general practitioners, psychologists and other health care providers has proven to be difficult. Health care providers outside the occupational context do not assess the inter-relationship between work and health, and thus, do not register whether work issues need to be addressed. Also, it is difficult for health care providers to refer patients to occupational health care providers as employers decide whether a consultation with the OP will take place since they pay for these services.

More attention for prevention and at-work performance

- *Ensure better labour law compliance.* The existing knowledge and expertise in the field of psychosocial risk prevention should be better used. The Arbo catalogues of the social partners provide valuable information, especially for small enterprises that do not have the resources to develop their own policy. It could be considered to oblige and monitor the use of these sector-specific catalogues. In addition, digital risk assessments, as opposed to pen-and-paper assessments, should become widely applied to improve compliance with the labour law (as advised by the Social and Economic Council of the Netherlands). Finally, companies not complying with the law should be sanctioned accordingly.
- *Provide the opportunity for preventive consultations.* As the employer is currently deciding whether a consultation with the OP takes place, this is often only done in case of sickness absence whereas workers do not get any opportunity to discuss concerns

related to work and health to prevent absences. Even if a preventive consultation is possible, asking permission from the employer for such a consultation puts the worker in a vulnerable position regarding the confidentiality of medical problems. One solution is to reinstall the obligation for employers to freely offer workers the possibility of a preventive consultation with an occupational health care provider to discuss work and health issues. Another possibility is to incorporate a preventive consultation with an occupational health care provider in people's health care insurance. This way, also unemployed people, temporary workers and self-employed people have the opportunity to use preventive consultations.

Strengthen the occupational health knowledge in companies.

- *Develop a professional profile for return-to-work case managers.* The task of monitoring the return-to-work process and related actions of the employer and worker has been transferred from OPs to return-to-work case managers. Although OPs can still be hired by employers as case managers, often other people without a (para)medical background fulfil the role of return-to-work case manager. Up till now, there is no official professional profile for these case managers. A clear profile, including specific qualifications, needs to be developed to professionalise the work of the return-to-work case manager, to ensure high quality and equal treatment for all workers, and to clearly delineate the responsibilities of the OP and the return-to-work case manager and their collaboration. Considering the large group of sickness absentees with mental health problems, return-to-work case managers should be required to have expertise on mental disorders and the interplay between work-related factors and mental health.

- *Ensure the neutral position of OPs (and return-to-work case managers).* Many workers believe that the OP defends the interests of the employer rather than their own. Possible solutions include: better informing workers on the role of their OP, making the OP more visible for workers to build-up a trust relationship, and explaining the rights of workers in consulting an OP. At the same time, OPs experience that their neutrality is sometimes at stake due to pressure from the employer who can choose to hire another OP. To avoid this problem, a more radical solution would be needed to change the position of the OP with regards to the employer. For example, the Netherlands Society of Occupational Medicine (NVAB) suggested organising occupational health care at the branch level: employers keep their responsibility to invest in

occupational health management by financing their branch-related occupational health care service, but the direct relationship between the employer and the OP is neutralised.

Improve collaboration between general practitioners, occupational physicians and psychologists

- *GPs and psychologists need to address the topic of work.* Discussing whether work is impacting a worker's health and vice versa, should become standard protocol for GPs and psychologists. This way they can raise the worker's awareness for the need to contact the OP to further evaluate how the interference between work and health can be dealt with. Ideally, GPs and psychologists should be able to refer the worker to the OP, with the employer bound to adhere.
- *OPs need to contact GPs and psychologists.* It should become standard protocol for the OP to contact the worker's GP and, if applicable, psychologist, if approved by the worker.
- *Use of guidelines needs to be stimulated.* OPs, GPs and psychologists all have guidelines on the treatment of workers with mental health problems which delineate recommendations for improving communication with the other professions. There is also a multidisciplinary guideline explaining the different roles of and co-ordination between the three professions for the treatment of workers with adjustment disorders and burnout specifically. Adherence to and active use of these guidelines should be achieved, for example through repeated information sessions and training on how to use the guidelines.

Notes

1. Firms with up to 20 employees accounted for 97% of all firms in the Netherlands in 2013 (*Source:* Statistics Netherlands: http://statline.cbs.nl, accessed 28 March 2014).
2. There are currently (April 2013) 107 certified Arbo services in the Netherlands (*Source:* www.sbca.nl/p/1/78/Arbo-dienst, accessed 28 March 2014).
3. The survey is representative for all companies in the Netherlands and does not solely focus on companies which are more likely to fail labour law compliance (Arbeidsinspectie, 2011).
4. www.arboportaal.nl (accessed 15 September 2014).
5. The National Survey of Working Conditions is a nationally representative survey among nearly 23 000 employees aged 15-64 working and living in the Netherlands (Koppes et al., 2012).
6. These Acts resulted in: i) an extension of wage payment during sickness absence by the employer from two (small employers) or six (large employers) weeks in 1994 to 52 weeks in 1996 and eventually to 104 weeks (regardless of employer size) in 2004; and ii) the enforcement of a protocolled reintegration process in which the employer and employee are both responsible for reintegration and sanctioned when not collaborating.
7. In the large majority of collective labour agreements, employers have agreed to pay 100% of the salary in the first year (OECD, 2008). About 80% of the workforce is covered by collective agreements in the Netherlands (SER, 2013). However, the law stipulates that employers cannot pay more than 170% of the salary over the two-year period.
8. About 42% of the employers are member of a branch organisation in their sector (Oeij et al., 2013).
9. Unfortunately no statistics exist on the number of companies employing such social worker.

References

Arbeidsinspectie (2011), *Arbo in Bedrijf 2010* [Health and safety at work 2010], Ministerie van Sociale Zaken en Werkgelegenheid, Den Haag.

Arends, I., J. van der Klink, W. van Rhenen, M. de Boer, and U. Bültmann (2013), "Predictors of Recurrent Sickness Absence Among Workers Having Returned to Work After Sickness Absence Due to Common Mental Disorders", *Scandinavian Journal of Work, Environment and Health*, Epub ahead of print.

Bakker, R., G. Dijkstra and J. van der Klink (2011), *Stressmanagement: Een Zoektocht naar Bruggen tussen Wetenschap en Praktijk, Eindrapport van het Project Stressmanagement* [Stress Management: a Search for Building Bridges Between Science and Practice, Final Report from the Stress Management Project], Ministerie voor Sociale Zaken en Werkgelegenheid, Den Haag.

Batenburg R., D. van Hassel, and I. van der Lee (2012), "Knelpunten in de arbocuratieve samenwerking tussen bedrijfsartsen en de eerstelijnszorg" [Barriers for collaborative sickness management between occupational physicians and primary care], NIVEL, Utrecht.

Capaciteitsorgaan (2013), *Capaciteitsplan 2013 voor de medische, tandheelkundige, klinisch technologische, geestelijke gezonheid-, en aanverwante (vervolg)opleidingen* [Capacity Plan 2013 for Medical, Dental, Clinical Technological, Mental Health and Related (Post) Education], Capaciteitsorgaan, Utrecht.

de Graaf, R., M. Tuithof, S. van Dorsselaer and M. ten Have (2012), "Comparing the Effects on Work Performance of Mental and Physical Disorders", *Social Psychiatry and Psychiatric Epidemiology*, Vol. 47, No. 11, pp. 1873-1883.

de Jong, P., T. Everhardt, and C. Schrijvershof (2011), "Toepassing van de wet Verbetering Poortwachter" [Application of the Gatekeeper Improvement Act], *APE*, Den Haag.

de Zwart B., R. Prins, and J. van der Gulden (2011), "Onderzoek naar de positie van de bedrijfsarts: Eindrapport" [Research on the position of the occupational physician: Final report], Astri Beleidsonderzoek- en advies, Leiden.

European Agency for Safety and Health at Work (2010), "European Survey of Enterprises on New and Emerging Risks (ESENER)", Managing Safety and Health at Work.

European Agency for Safety and Health at Work (2009), "European Survey of Enterprises on New and Emerging Risks (ESENER)," Managing Safety and Health at Work.

Hesselius, P. and M. Persson (2007), *Incentive and Spill-Over Effects of Supplementary Sickness Compensation*, Institute for Labour Market Policy Evaluation, Uppsala.

Hooftman, W. et al. (2012), "Arbobalans 2011: Kwaliteit van arbeid, effecten en maatregelen in Nederland" [Health and safety balance 2011: quality of labour, effects and measures taken in The Netherlands], TNO, Hoofddorp.

Inspectie SZW (2012), *Jaarverslag 2012* [Annual report 2012], Ministerie Sociale Zaken en Werkgelegenheid, Den Haag.

Johansson, P. and M. Palme (2004), *Moral Hazard and Sickness Insurance: Empirical Evidence from a Sickness Insurance Reform in Sweden*, Institute for Labour Market Policy Evaluation, Uppsala.

Koletsi M. et al. (2009), "Working with Mental Health Problems: Clients' Experiences of IPS, Vocational Rehabilitation and Employment", *Social Psychiatry and Psychiatric Epidemiology,* Vol. 44, No. 11, pp. 961-970.

Koopmans, P., U. Bültmann, C. Roelen, R. Hoedeman, J. van der Klink and J. Groothoff (2011), "Recurrence of Sickness Absence Due to Common Mental Disorders", *International Archives of Occupational and Environmental Health*, Vol. 84, No. 2, pp. 193-201.

Koopmans, P., C. Roelen and J. Groothoff (2008),"Frequent and Long-term Absence as a Risk Factor for Work Disability and Job Termination Among Employees in the Private Sector", *Occupational and Environmental Medicine*, Vol. 65, pp. 494-499.

Koppes, L., M. van Zwieten, W. Hooftman, H. Lautenbach, E. de Vroome, and S. van den Bossche (2012), *Nationale Enquête Arbeidsomstandigheden 2011: Vinger aan de pols van werkend Nederland* [The National Survey of Working Conditions 2011: Paying Close Attention to the Working Population in The Netherlands], TNO, Hoofddorp.

LVE, NHG and NVAB (2011), *Richtlijn: Eén lijn in de eerste lijn bij overspanning en burnout: Multidisciplinaire richtlijn bij overspanning en burnout voor eerstelijns professionals* [Guideline: One Direction in Primary Care for Distress and Burnout: Multidisciplinary Guideline on Distress and Burnout for Primary Care Professionals], Landelijke Vereniging Eerstelijnspychologen, Amterdam, Nederlands Huisartsen Genootschap, Utrecht, Nederlandse Vereniging voor Arbeids- en Bedrijfsgeneeskunde, Utrecht.

Markussen, S., A. Mykletun and K. Røed (2012), "The Case for Presenteeism – Evidence from Norway's Sickness Insurance Program", *Journal of Public Economics*, Vol. 96, Nos. 11-12, pp. 959-972.

Mutual Information System on Social Protection (MISSOC), www.missoc.org (accessed 15 September 2014).

Nieuwenhuijsen, K. et al. (2003), "Quality of Rehabilitation Among Workers with Adjustment Disorders According to Practice Guidelines: A Retrospective Cohort Study", *Occupational and Environmental Medicine*, Vol. 60, Suppl. 1, pp. i21-i25.

Noordik, E. et al. (2011), "Exploring the Return-to-Work Process for Workers Partially Returned to Work and Partially on Long-term Sick Leave Due to Common Mental Disorders: A Qualitative Study", *Disability and Rehabilitation*, Vol. 33, pp. 1625-1635.

NVAB (2013), "Leidraad casemanagement bij ziekteverzuimbegeleiding" [Guideline case management for sickness management], Nederlandse Vereniging voor Arbeids- en Bedrijfsgeneeskunde, Utrecht.

NVAB (2007), "Richtlijn: Handelen van de Bedrijfsarts bij Werkenden met Psychische Problemen" [Guideline for the occupational physician: Acting on workers with mental health problems], Nederlandse Verenining voor Arbeids- en Bedrijfsgeneeskunde, Utrecht.

NVMW (2009), "Bedrijfsmaatschappelijk werk en het re-integratieproces: Richtlijn voor bedrijfsmaatschappelijk werkers bij werkhervatting en re-integratie van medewerkers" [Company social work and the reintegration process: Guideline for company social workers on work resumption and reintegration of employees], Nederlandse Verening van Maatschappelijk Werkers, Utrecht.

OECD (2012), *Sick on the Job? Myths and Realities about Mental Health and Work*, OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264124523-en.

Oeij, P., E. de Vroome, K. Kraan, A. Goudswaard and S. van den Bossche (2013), *Werkgevers enquête arbeid 2012: Methodologie en beschrijvende resultaten* [Employer Labour Survey 2012: Methodology and Descriptive Results], TNO, Hoofddorp.

Oomens P., J. Huijs and R. Blonk, (2009), "Obstakels in werk: wat belemmert werkhervatting bij werknemers met psychische klachten?" [Obstacles to working: what hinders work resumption in workers with mental health problems?], *Tijdschrift voor Bedrijfs- en Verzekeringsgeneeskunde*, Vol. 17, pp. 231-236.

Rebergen, D. et al. (2010), "Return to Work and Occupational Physicians' Management of Common Mental Health Problems – Process Evaluation of a Randomized Controlled Trial", *Scandinavian Journal of Work, Environment and Health*, Vol. 36, No. 6, pp. 488-498.

Rebergen, D. et al. (2006), "Adherence to Mental Health Guideline by Dutch Occupational Physicians", *Occupational Medicine (London)*, Vol. 56, No. 7, pp. 461-468.

Romeijnders, C. et al. (2005), "Landelijke Eerstelijns Samenwerkings Afspraak Overspanning" [National primary care collaborative agreement on distress], *Huisarts en Wetenschap*, Vol. 48, No. 1, pp. 20-23.

SCP (2012), *Belemmerd aan het werk: Trendrapportage ziekteverzuim, arbeidsongeschiktheid en arbeidsdeelname personen met gezondheidsbeperkingen* [Working With a Disability: Trend Analysis on Sickness Absence, Work Disability and Labour Market Participation of People with Disabilities], Sociaal Cultureel Planbureau, Den Haag.

SER (2013), "Veelgestelde vragen over het advies draagvlak voor cao-afspraken" [Frequently asked questions about the advice on support for collective labour agreements], Sociaal Economische Raad, www.ser.nl/nl/publicaties/adviezen/2010-2019/2013/verbreding-draagvlak-cao-afspraken/faq.aspx#06 (accessed 22 November 2013).

SER (2012), *Stelsel voor gezond en veilig werken* [System for Health and Safety at Work], Sociaal Economische Raad, Den Haag.

Stansfeld, S. and B. Candy (2006), "Psychosocial Work Environment and Mental Health – A Meta-analytic Review", *Scandinavian Journal of Work and Health*, Vol. 32, Special Issue No. 6, pp. 443-462.

Steenbeek, R., W. Hooftman, G. Geuskens and C. Wevers (2010), "Objectiveren van gezondheidsgerelateerde nonparticipatie en de vermijdbare bijdrage van de gezondheidszorg hieraan" [Objectifying health-related non-participation and the avoidable contribution to this by the health care system], TNO, Hoofddorp.

SZW (2013a), *Hoofdlijnen aanpak psychosociale arbeidsbelasting* [Main Features of the Approach to Psychosocial Work Demands], Ministerie van Sociale Zaken en Werkgelegenheid, Den Haag.

SZW (2013b), "Re-integratie 2e spoor" [2nd track reintegration], Ministerie van Sociale Zaken en Werkgelenheid, www.arboportaal.nl (accesssed 8 November 2013).

UWV (2012), *UWV Jaarverslag 2012: Publieksversie* [UWV Annual Report 2012: Public Version], Uitvoeringsinstituut Werknemersverzekeringen, Amsterdam.van der Burg, C., V. Veldhuis, and L. von Meyenfeldt (2010), "Overweging rond de inzet van re-integratie en de claimaanvraag bij langdurig zieken" [Consideration of the usage of reintegration and the claim request for long-term sick], Astri, Leiden.

van der Helm (2013), "The Privacy Protection of the Sick Employee: The Dutch Case from a Comparative Perspective", *European Journal of Social Security*, Vol. 15, No. 3, pp. 273-296.

van Sonsbeek, J. and R. Gradus (2011), *Estimating The Effects of Recent Disability Reforms in the Netherlands*, Tinbergen Institute, Amsterdam.

Chapter 4

Employment support in the Netherlands for people out of work

This chapter looks at the ability of the Dutch public employment service and the municipalities to deal with the high prevalence of mental illness among their clients. It looks successively at the main issues for the key client groups – unemployed people, sickness and disability beneficiaries and social assistance beneficiaries – with a particular focus on the activation support provided to clients with mental ill-health. The chapter also addresses the implications of the major reforms that are being implemented in the Netherlands: the continued shift of responsibilities over sickness management onto employers and the increasing role for municipalities in activating clients with the strongest labour market disadvantages.

Over the past two decades, the responsibility for the management of sickness among Dutch employees has been increasingly shifted onto employers. This strategy turned out to be very successful and significantly reduced both the sickness absence rate and the number of new disability benefit claims. In the coming years, also the responsibility of municipalities in supporting people to participate in work will expand significantly. Nevertheless, for some groups the Employee Insurance Agency (UWV) will remain the key actor for providing support. To avoid incapacity due to mental ill-health among these clients, UWV has an important role to play in providing early intervention and multidisciplinary support.

The clients of UWV and the support they receive

Broadly speaking, there are three groups of people that rely on UWV for support: unemployed people, workers who remain sick until after the end of their employment contract and disability beneficiaries. UWV is responsible for paying income support and supporting them in their return to work. Within UWV, the department of public employment services deals with unemployment beneficiaries while the department of social and medical affairs is responsible for providing support to sickness and disability beneficiaries.

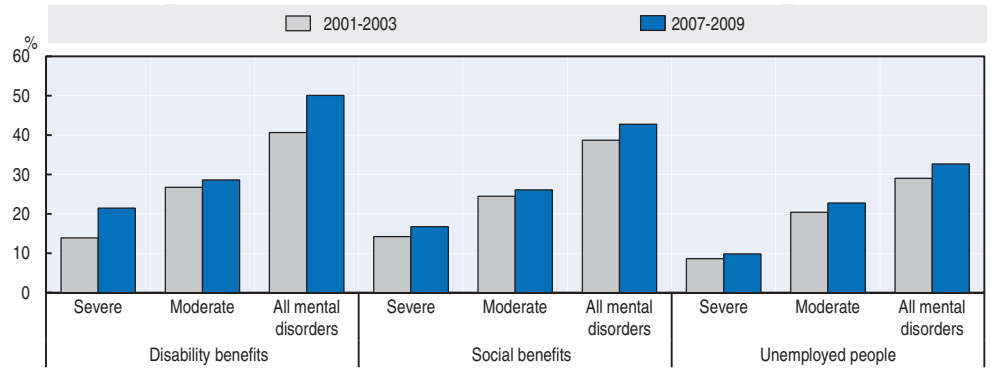
Mental ill-health not only presents a major challenge for the disability benefit schemes but also for the other working-age benefit schemes. Data from the Dutch POLS Health Survey for the three-year period 2007-09 illustrate that one third of the unemployed people is estimated to have a mental disorder and 43% of those relying on social benefits, a share nearly as high as in the disability benefit system (Figure 4.1).[1] The share of people with either a severe or moderate mental disorder has increased over time in all systems.

The high share of mental health problems among its clients poses particular challenges for UWV. Chances for a successful reintegration diminish very quickly the longer people are away from work. Therefore, employment support is needed before clients are "cured", but finding a new job for clients with mental ill-health is difficult due to stigma. Close co-operation with mental health services is essential to successfully activate clients with mental ill-health, even for those with mild problems (see also Chapter 5 for a discussion of the covenant between UWV and the mental health sector).

In the following sections, the different types of beneficiaries and the support UWV provides are discussed in detail, with a focus on whether and how mental health issues are addressed.

Figure 4.1. **A major share of people receiving income-replacement benefits suffer from a mental illness**

Share of disability and social assistance beneficiaries and unemployed people with a mental disorder by severity of mental disorder



Source: OECD calculations based the POLS Health Survey, 2001-03 and 2007-09.

StatLink http://dx.doi.org/10.1787/888933145543

Unemployed people

One third suffers from a mental health problem

In 2012, about 613 000 new unemployment benefits were granted (UWV, 2013a). The unemployment rate in the Netherlands has been steadily increasing since the economic crisis, from 3.0% in 2008 to 5.3% in 2012 (OECD, 2011; OECD, 2013b). Even so, unemployment remains very low compared to OECD levels (8.2% on average in 2013) and the share of long-term unemployment equals the average of 34%.

Little information is available about the mental health status of unemployment beneficiaries, but the Dutch POLS Health Survey reveals that about one third of all unemployed people have a moderate or severe mental disorder (see Chapter 1), which is in line with findings in other OECD countries (OECD, 2012). As in other working-age benefit schemes, the share of people with a mental disorder increased slightly over time among unemployed people.

The maximum duration of benefit recipiency in the Netherlands is one of the longest in the OECD (OECD, 2014), yet the Dutch unemployment insurance system has a rather strong focus on a fast return to work with strict job-search and availability requirements (Venn, 2012). The government has plans to further strengthen the system as of 2016 (see Box 4.1 for a description of the Dutch unemployment insurance system).

Box 4.1. **Unemployment insurance in 2014**

To be eligible for unemployment benefits, the applicant must have worked 26 out of the 36 weeks preceding unemployment, with a minimum of one working hour a day (holidays included). Employees who are culpable unemployed are not entitled to unemployment benefits.

The maximum duration of the unemployment benefit period is between 3 and 38 months, depending on the number of years worked. To receive benefits longer than three months, the person must have worked four years or more over the last five years before becoming unemployed, with a minimum of 208 hours/52 days of paid work a year. Every year with more than 208 hours/52 days of work gives the person the right to one month of unemployment benefit.

The unemployment benefit is not means-tested: for the first two months, the benefit is 75% of the salary earned during the last year preceding unemployment. After that, the replacement rate is 70%. The minimum benefit for a single person aged 18 is EUR 20.47 and the maximum benefit is EUR 197 (gross) per day.

Unemployed people are required to apply for jobs at their professional level during the first six months; during the following six months they should also apply for jobs at lower levels. If after 12 months the person has not been successful, they are obliged to take any job offer. The requirement is to submit at least four applications every four weeks. If the search criteria are not fulfilled, sanctions such as a freeze of benefits can be applied.

The government has recently accepted a new reform of the unemployment benefits to further increase job-search incentives and shorten inactivity periods. As of January 2016, the maximum duration will be gradually reduced to a maximum of two years by 2019, but social partners will be allowed to prolong the maximum duration of benefit recipiency by 14 months through collective agreements. In addition, jobseekers will be required to accept any job (including those below their professional level) after six months on unemployment instead of after 12 months.

UWV support for unemployment beneficiaries is digitalised

Severe budget cuts over the period 2011-15 imply halving the budget for employment services as well as the number of staff and closing down two third of the UWV offices. To concentrate the remaining resources on disadvantaged clients, since mid-2013 UWV has used a digitalised system in which 90% of its unemployment beneficiary clients have to rely solely on e-services (UWV, 2013b). Clients who are not (yet) able to use the online services can get personalised support until 2015, after that, group workshops will be organised. During the first three months of unemployment, all contact with UWV goes through the internet: benefit administration, job search and applications, as well as online workshops and trainings. After three months, unemployment beneficiaries are evaluated to see whether or not they are eligible for intensive support. The evaluation is currently still done face-to-face with an UWV caseworker, but the intention is to replace it by a digital questionnaire (so-called "work explorer"; see Box 4.2 for a short description). For budgetary reasons, only the 10% most disadvantaged jobseekers (i.e. those with a large

distance to the labour market) will be entitled to intensive support (such as individual and group coaching and in-depth work assessments; UWV, 2012a) for nine months. After one year of unemployment, all intensive support ends.

UWV is still developing its digital support system based on national and international experiences with e-services in the health sector (UWV, 2013c) in combination with strategies from behavioural science – such as communication science, marketing and social psychology – to influence the behaviour and motivation of jobseekers (UWV, 2012a; Bijlert et al., 2012). In particular, an interactive website to stimulate people to undertake action and a wide variety of support services to target support to the weaknesses of a jobseeker (as revealed by the digital questionnaire) are necessary elements of a proper digital system. Currently, many of these ideas are still theory, but if and when applied, the system could become a very powerful tool for UWV. The possibility to offer internet-administered cognitive behaviour therapy for depression and anxiety as part of UWV support is a particularly interesting feature for jobseekers with mental health problems (Cuijpers et al., 2008; Andrews et al., 2010).

Box 4.2. **Work explorer**

UWV developed a digital questionnaire, called "work explorer", to determine the chances of a jobseeker to resume work within a year. Each jobseeker fills in the questionnaire electronically before three months of unemployment. The outcome of the questionnaire determines whether or not the jobseeker is entitled to intensive support as well as the kind of support that is necessary to increase the chances to find a job.

The questionnaire consists of a list of 20 questions on hard factors (such as age, job tenure and knowledge of the Dutch language) as well as soft factors (such as personal view on the chance to return to work, health perception, active job-search behaviour and physical and psychological work capacity). The selection of the questions is based on an extensive literature review and an econometric analysis to select the questions with the highest predictive power (Brouwer et al., 2011).

Currently the questionnaire is being evaluated and expanded to improve the accuracy for specific client groups. A second version of the questionnaire is expected by 2016.

Source: UWV (2012), *UWV Kennisverslag 2012-2* [UWV Knowledge report 2012-2], Uitvoeringsinstituut Werknemersverzekeringen, Amsterdam.

The long-term impact of the digitalisation of UWV support is yet to be seen and should be monitored closely, especially if the digital system is not quickly developed into a comprehensive support system with all the features described in the UWV knowledge reports (see UWV, 2012a, and UWV, 2013c). Otherwise, short-term savings for UWV could well turn into an increase in the costs for society in the long run, especially in other parts of the Dutch social protection system, such as sickness and disability benefits and social welfare. From other countries it is known that early

employment support is crucial for people with a mental disorder who lose their job, as a return to work is far more likely if support comes at the beginning of the unemployment spell, before health problems aggravate (OECD, 2012). After one year of unemployment, chances for returning to work become very slim. Given the multitude of challenges for people with mental health problems (such as behavioural and attitudinal factors, but also co-morbid health problems and multiple psychosocial issues), support in co-operation with the mental health sector (and potentially the care sector) will be necessary to avoid long-term labour market withdrawal. Such support cannot solely be provided through a digitalised system, however.

In addition, the digital questionnaire will not necessarily identify jobseekers with mental disorders, while this would be essential given the abovementioned importance of early action for this group of jobseekers. The questionnaire contains one question on mental work ability, but assessing one's mental work ability as "good" does not mean that someone does not have a mental disorder. Other aspects related to a mental disorder might still influence chances of finding work. Also, people may not want to reveal that their mental health problems interfere with their work ability due to stigma. Clinical-epidemiological research suggests that asking people directly about the existence of a mental illness does not give reliable outcomes (OECD, 2012). To better signal and monitor people with mental health problems, a validated mental health instrument could be included in the digital questionnaire (e.g. the Kessler Psychological Distress Scale – 10 items – or the General Health Questionnaire – 12 items).

Finally, it is questionable whether all UWV clients will be able to fully use the digital system. The far majority (87% in 2012) of jobseekers registers online, yet nearly half of them (43%) received support to do so, mainly from friends and family (van Rens et al., 2012; UWV, 2013d). For this group – in addition to those who are currently not even registering online (13% of UWV clients) – it may prove particularly difficult to make use of the support and workshops that are digitally offered by UWV.

Vangnetters

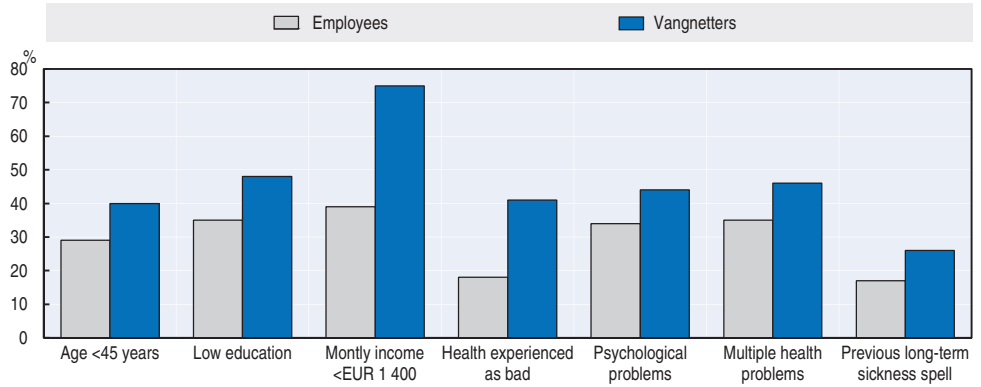
Vangnetters are a vulnerable group

While employers are responsible for paying sickness benefits and managing the return to work of their sick employees (see Chapter 3), this responsibility stops as soon as the contract comes to an end. Employees who experience sickness absence until after the end of their contract are covered by a collective sickness fund (i.e. Ziektewet) and rely on UWV for support (so-called "vangnetters").[2] In 2013, there were approximately 96 000 vangnetters of which 63 000 experienced a sickness duration of minimal 13 weeks (UWV, 2013a).

Vangnetters form a vulnerable population. A survey undertaken among employees and vangnetters on long-term (nine months) sick leave in 2012 reveals that, compared with their counterparts, sick vangnetters are younger, have a lower educational level and monthly income, experience their general health as worse and report more often previous sickness spells (Figure 4.2). Nearly half (44%) of the vangnetters on long-term sick leave have psychosocial problems (such as debt, juridical problems, divorce, domestic violence, care tasks, substance abuse, etc.) compared with one third among sick employees with stable employment. Similar shares hold for the presence of multiple health problems. Another study reveals that about 22% of vangnetters on long-term sick leave (here defined as six months) have severe mental health problems and 17% more moderate mental health problems (van der Burg, 2011).

Figure 4.2. **Vangnetters form a vulnerable population**

Characteristics of vangnetters and employees on long-term (nine months) sick leave



Source: van der Burg, C. et al. (2013), *Weg naar de WIA: Langdurig zieken 2012* [Road to the WIA: Long-term sick 2012], AStri Beleidsonderzoek en -advies, Leiden.

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The risk to eventually claim disability benefits is twice as high for vangnetters as for employees: 55% of the vangnetters who have been on long-term sick leave claim disability benefits about a year later, compared with 26% of sick employees with a regular employer (de Jong et al., 2010). At the same time, their claim gets more often rejected. Nevertheless, with 52% of the inflows in the WIA benefit system in 2012 (UWV, 2012b), vangnetters are highly over-represented in the Dutch disability system.

In part, the higher risk for vangnetters to enter the disability system is explained by their personal disadvantages, but also the lack of an employer

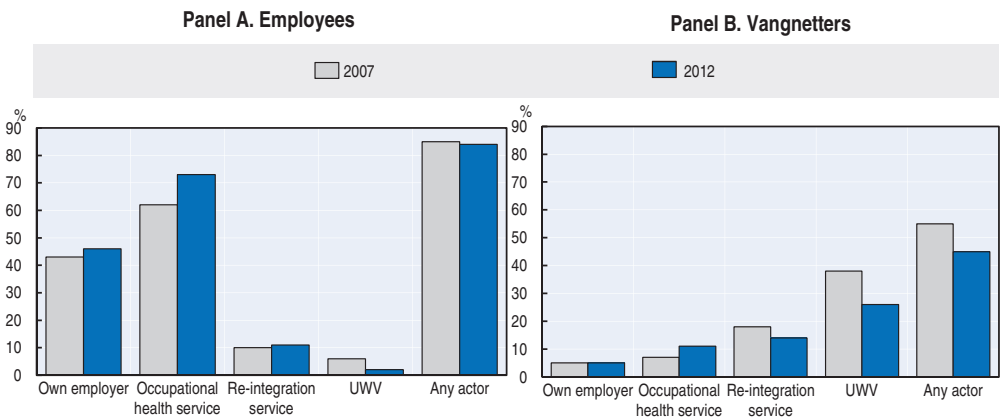
and underdeveloped services by UWV are important elements in explaining the difficulties sick vangnetters experience in successfully returning to work (SCP, 2012; de Jong et al., 2009).

UWV support for vangnetters is insufficient

Sickness management and reintegration of vangnetters into work by UWV remains below par. Where 84% of workers with stable employment on long-term sickness absence reported that they had received reintegration support in 2012, only 45% of the sick vangnetters did so (Figure 4.3*)*. While UWV is responsible for assisting sick vangnetters in their work resumption, only one in four received reintegration support from UWV in 2012, a considerable decline from 2007 when more than one third of the vangnetters did so – despite the fact that the department Social Medical Affairs, which is responsible for providing support to sick vangnetters, is not (yet) affected by the budget cuts and digitalisation process discussed above. Also support from private reintegration services declined, from 18% in 2007 to 14% in 2012. Van der Burg et al. (2013) argue that the economic crisis and the increase in unemployment discouraged UWV to invest in reintegration support as there are fewer jobs available.

Figure 4.3. **Sick vangnetters receive much less reintegration support than sick employees**

Share of sick employees and vangnetters receiving support from different actors in the work resumption process



Note: Several answers are possible; the bars do not sum up to 100%.

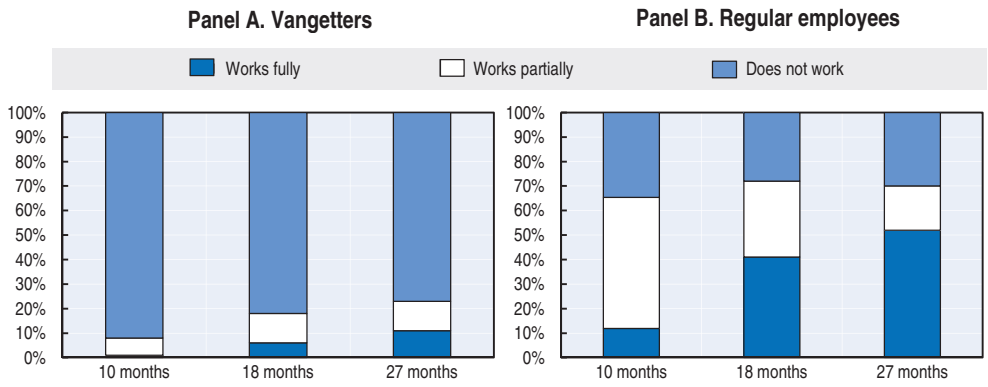
Source: van der Burg, C. et al. (2013), *Weg naar de WIA: Langdurig zieken 2012* [Road to the WIA: Long-term sick 2012], AStri Beleidsonderzoek en -advies, Leiden.

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A closer look at the type of support people received reveals that only 25% of the long-term sick vangnetters reports to have undergone a problem analysis, despite the legal obligation to do this within six weeks of sickness. In addition, 32% reports that a work plan had been developed – as opposed to employers UWV does not have the legal obligation to do this within eight weeks of sickness if the vangnetter is expected to have no capacity to work on the short term (van der Burg, 2011. van der Burg et al., 2013).[3] While evidence shows that intensive support from the beginning greatly improves the work resumption of people with severe mental health problems, only 12% of the long-term sick vangnetters received such support (van der Burg, 2011). The same study points out that a meeting with the insurance doctor or reintegration specialist is the most frequently offered support type by UWV. Yet, only few long-term sick vangnetters with mental health problems benefit from it: half of those with severe mental disorders and one third with more moderate disorders. In sum, with the current economic crisis and the limited sickness management support from UWV, it is not surprising that among vangnetters with long-term sickness absences, only 8% returned to paid work within ten months compared with 66% of workers with stable employment (Figure 4.4). The situation hardly improves after that: after 27 months of sickness absence, barely one in four sick vangnetters are working again. These outcomes are very poor, especially knowing that 80% of the long-term sick vangnetters are capable of working again (van der Burg, 2011).

Figure 4.4. **Very few vangnetters on long-term sick leave resume work**

Work resumption after 10, 18 and 27 months by vangnetters and employees on long-term (nine months) sick leave



Source: de Jong, P. et al. (2010), *Nederland is niet meer ziek: Van WAO-debakel naar WIA-mirakel* [The Netherlands is no longer sick: From WAO-debacle to WIA-miracle], APE/AStri Beleidsonderzoek en -advies.

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Recent reforms to improve early intervention do not sufficiently address the role of UWV

To restrict sickness absence and work disability among vangnetters a new law consisting of four measures was introduced in January 2013. First, eligibility for the second year of sickness benefits is restricted. After the first year of sickness absence, a vangnetter will lose the right to sickness benefits if able to earn 65% of the average income (based on education and experience) as judged by UWV. Second, vangnetters need to adhere to a strict reintegration policy. They are obliged to apply for jobs, participate in educational trajectories, collaborate in test placements and co-operate in managing debts and addiction problems (if applicable). Third, the maximum period of a test placement with an employer is extended from three to six months, on the condition that the vangnetter is hired at the end of the trial period. During the trial period, the vangnetter keeps the sickness benefits so the employer does not need to pay salary. Fourth, since January 2014, premium differentiation is implemented for employers, which obliges them to pay a higher premium for sickness and disability benefits when a higher share of their former temporary employees end up on sickness or disability benefits after the end of the contract (Buijsman and Pepping, 2012).

In addition, temporary work agencies are now taking more responsibility to reintegrate sick temporary workers into a job. As of January 2013, two of the largest temporary work agencies became own risk carriers, implying that UWV is no longer responsible for paying their sickness benefits, nor for providing reintegration support. Initial results indicate that the total inflow into public sickness benefits of sick temporary agency workers declined by 60% (UWV, 2013b). Yet, it is the better performing agencies which became own risk carriers. With the other temporary work agencies UWV signed a covenant implying that the agencies are now responsible for looking for a new job for their sick temporary agency workers who still have sufficient functional abilities (as judged by UWV). A pilot project in 2012 in three temporary work agencies showed that 50% of the sick vangnetters who received reintegration support from their temporary work agency acquired work (Inspectie SZW, 2012a).

Both measures imply that UWV is devolving as much responsibilities as possible onto employers. Given the importance of having an employer who can offer adapted work, this responsibility shift is a very valuable strategy. Yet, it also means that UWV is increasingly confronted with the most difficult clients who need more intensive and personalised support. For instance, sick unemployed people and flex workers have a much higher risk of long-term absence than temporary agency workers (van der Hoek et al.,

2008). Improved sickness management by UWV will thus be a crucial determinant for reducing benefit dependence, in particular if UWV wants to sanction vangnetters who are not adhering to their reintegration plan. UWV has a relatively good reintegration structure with a strong focus on work resumption by all caseworkers, but too few sick vangnetters are benefitting from it. Having temporarily no work capacity due to illness (as assessed by insurance physicians) should be no reason for UWV caseworkers to postpone the development of an action plan for vangnetters. Support with and advice about continuing normal daily activities (as is done by OPs for sick, employed workers) could be part of a work plan for vangnetters – ideally set up in collaboration with mental health specialists. Also, participating in voluntary work for a few hours per week to build up a work rhythm could be advised in a work plan as a substitute of the therapeutic work that sick, employed workers are often offered by their employer. Delaying support will only make it more difficult to reintegrate vangnetters into the labour market, and given that a considerable share of vangnetters' claims for disability benefits is rejected, these people will eventually be shifted onto the municipalities for support.

UWV recently intended to improve its sickness management policy but not all challenges have been addressed. Since mid-2012, vangnetters are transferred within four to six weeks of sickness absence to a reintegration officer who co-ordinates the reintegration process. They are stimulated to find work themselves, but if this is not successful, the reintegration officer can look in the UWV network for suitable vacancies or buy services from reintegration bureaus (such as psychological treatment, coping and assertiveness training, competency tests or job interview training) to improve the vangnetter's chances of finding work. Nevertheless, reintegration officers report that the vacancies within UWV network are often not suitable for vangnetters (Inspectie SZW, 2012a). In addition, reintegration management of vangnetters is done by a separated division within UWV which does not collaborate with the caseworkers responsible for finding work for unemployed people, causing a discontinuation of support for unemployed people who fall sick.

Finally, there are not enough financial incentives for UWV to improve sickness management for their clients. Whereas employers in the Netherlands have strong incentives to fasten work resumption of sick employees – employers are penalised by a third year of sick pay in case of insufficient reintegration efforts – such incentives are lacking for UWV. Insufficient support for sick jobseekers who are unlikely to be eligible for disability benefits would imply additional costs for the municipalities (and for other parts of the society as well as for the individual) but not for UWV. In that sense, Denmark provides a good example of how institutional

incentives can be introduced. There, municipalities (i.e. the institutions responsible for reintegration) receive 65% reimbursement from the state budget for using reintegration measures for their clients but only 35% for the disability benefit costs and 30% for the costs for social assistance and unemployment exceeding eight weeks (OECD, 2013a). This set-up encourages early action and limits institutional passivity.

Limited co-operation with the mental health sector

Given the high prevalence of mental health problems among its clients, both unemployment beneficiaries and sickness beneficiaries, efficient co-operation of UWV with the mental health sector is crucial for reintegrating these people into work. Yet, a report by the Labour Inspectorate states that two thirds of the UWV insurance doctors and employment specialists have no or only incidental contacts with the mental health sector and only 39% agrees with the statement that collaboration with the mental health sector is necessary for clients with a mental disorder (Inspectie SZW, 2012b). Even so, qualitative and quantitative analyses show that regular contacts with the mental health sector have several advantages: better diagnosis of the work capacity, better selection of suitable reintegration trajectories, less focus on care and cost sharing of reintegration support. As such, the recent covenant between UWV and the mental health sector (see Chapter 5 for a detailed discussion) is a promising start.

WIA disability benefit system

After two years of sickness absence, people can apply for disability benefits with UWV. Claims of employees with a fixed employer are, however, only considered if the reintegration efforts of the employer and employee during the two preceding years of sickness are deemed sufficient. This was not the case for 19% of the files in 2012 (UWV, 2012a), in which case the employer had to pay a third year of sickness benefits.

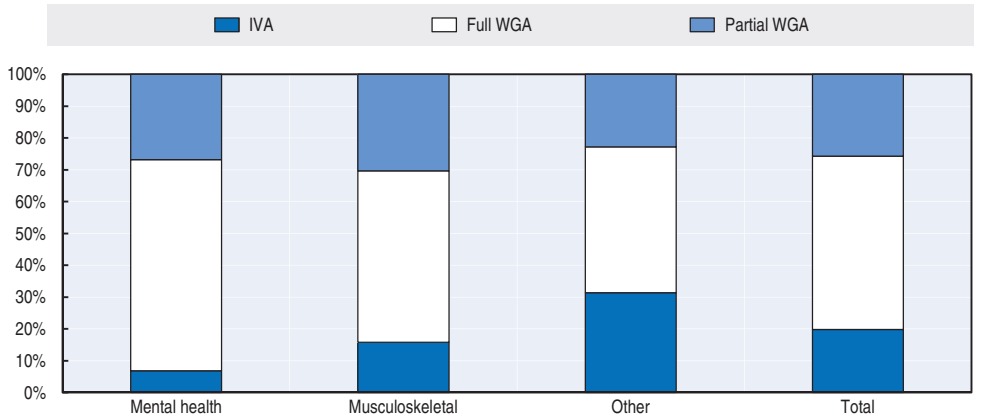
The majority receives a full benefit

Most people with a mental health problem enter the disability benefit system with a full, though temporary, benefit. The Law on Work and Income to Capacity (WIA), in place since 2006, consists of two benefit schemes: the return to work benefits for partially disabled persons (WGA) and the income scheme for fully disabled persons (IVA) (for more details about both schemes, see Box 4.3). The share of people who are considered fully and permanently disabled (permanent loss in earnings capacity of 80-100%) is small, accounting for 20% of the total number of new WIA grants and 7% among those with a mental disorder (Figure 4.5). Instead, the

majority (54%) of WIA entrants are considered fully disabled but with a chance to recover their earnings capacity. These people receive a full WGA benefit and account for 66% of the entrants with a mental disorder compared with 54% of those with musculoskeletal problems. In terms of benefit level, there is little difference between the IVA benefit and the full WGA benefit which are respectively 75% and 70% of the last earned wage. Only one fourth of all WIA beneficiaries are (financially) encouraged to resume work and to make full use of their remaining work capacity, i.e. those with partial WGA benefits, as their benefit drops considerably if they do not work after the initial phase of wage-related benefit (which lasts between 3 and 38 months depending on a person's work history; see Box 4.3).

Figure 4.5. **Three in four claimants enter the WIA system with a full disability benefit**

New claims into the WIA system, by type of benefit and health condition, 2012



Source: UWV (2012), *Kwantitatieve informatie 2012*, Uitvoeringsinstituut Werknemersverzekeringen, Amsterdam; and UWV (2013), *UWV Monitor Arbeidsparticipatie 2013*: *Aan het werk zijn, komen en blijven van mensen met een arbeidsbeperking,* Uitvoeringsinstituut Werknemersverzekeringen, Amsterdam.

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Box 4.3. **Disability benefit schemes in the Netherlands**

Employees who have been sick for two years and have an earnings capacity loss of more than 35% are eligible for disability benefits. The Law on Work and Income to Capacity (WIA) replaces since 2006 the Law on Invalidity Insurance (WAO) and consists of two schemes, the return to work benefits for partially disabled persons (WGA) and the income scheme for fully disabled persons (IVA).

Return to work benefits for partially disabled persons (WGA)

The WGA is an income compensation scheme for people who are partially disabled (with an earnings capacity loss of at least 35% and at maximum 80%) and for those who are fully but temporarily disabled. There are three types of WGA: the wage-related benefit, the wage supplement, and the follow-on benefit.

To be eligible for the *wage-related WGA benefit*, the person must have worked for at least 26 out of the 36 weeks preceding disability. The benefit level and duration depend on the former salary, labour history and potential current salary. During the first two months, the benefit is calculated as 75% of the last earned wage minus 75% of the current wage; thereafter, it becomes 70% of the last wage minus 70% of the current wage. In 2014, the maximum benefit level is EUR 3 214 per month in the first two months and EUR 2 999 per month thereafter. The duration depends on the individual's employment history and varies between 3 and 38 months.

When the wage-related WGA benefit comes to an end, beneficiaries with a partial loss in earnings capacity are entitled to a *WGA wage supplement* on the condition that they earn at least 50% of their remaining work capacity; otherwise they receive a *WGA follow-on benefit*. Those who are fully but temporary disabled continue to receive the wage supplement benefit.

- The wage supplement depends on the former and current wage: if the beneficiary earns between 50 and 100% of their remaining work capacity, they receive 70% of the last wage minus 70% of their remaining work capacity; if they earn 100% or more, they get 70% of the last wage minus 70% of the current wage.
- The follow-on benefit is calculated on the basis of the minimum wage, ranging from 28% of the minimum wage for a person with a work incapacity of 35-45% to 50.75% of the minimum wage for a person with a work incapacity of 65-80%.

An assessment can be carried out each month to establish the type and amount of the WGA benefit in relation to the earning capacity and current wage. Unless there is a change in health condition, beneficiaries can claim a WGA benefit until their 65th birthday.

Income scheme for fully disabled persons (IVA)

The IVA is an income compensation scheme for fully (earnings capacity loss of at least 80%) and permanently disabled people who are no longer able to work and have little chance of recovery. A person can also qualify for IVA before the two years of absence have elapsed if it is clear that the incapacity is fully and permanent.

Box 4.3. **Disability benefit schemes in the Netherlands** *(cont.)*

IVA benefits amount to 75% of the last earned income (with a maximum of EUR 3 214 per month in 2014). IVA benefits can be received until retirement age. If someone recovers and is able to work again, they can apply for a temporary WGA benefit. IVA beneficiaries who work and earn 20% or more of their last earned wage during one year are reassessed by UWV.

The IVA benefits are financed through uniform employer contributions.

Invalidity insurance (WAO)

The WAO benefit is only applicable to people who entered the scheme before January 2006, and who are at least 15% incapacitated. The benefit level depends on the level of earnings capacity loss, the age of the beneficiaries and the type of benefit (initial or follow-up benefit), with a maximum of 75% of the previous wage. The average benefit was EUR 52 per day in 2012.

Reassessment is relatively frequent, but rarely leads to a change in benefit status. Roughly one-fourth of the total WIA benefit population has been reassessed at least once (de Jong et al., 2013). Of the full WGA beneficiaries that entered the system in 2006, 60% have been evaluated in the meanwhile. Even so, 61% of the reassessments that took place in 2012 implied a confirmation of the benefit status, 27% moved into a more generous benefit scheme (e.g. from WGA to IVA or from partial WGA to full WGA), 8% left the system (unclear whether they leave the system with a job) and a negligible number moved from full into partial WGA (UWV, 2012b). People with mental disorders are least likely to move from WGA into IVA benefits (Berendsen, 2012).

According to de Jong et al. (2013), the strong eligibility conditions for the WIA benefit system, and in particular for IVA benefits, imply that beneficiaries typically have very severe conditions and improvements are unlikely. Yet, a disability is only considered permanent when there are no treatment options available anymore which could improve the person's earnings capacity. This condition explains why the majority of WIA beneficiaries with a mental disorder receive full but temporary WGA benefits. In addition, many WIA beneficiaries have a low education level and an irregular work history with low wages. For this group, even with remaining work capacities, it is thus difficult to find a job that would pay at least the minimum wage, which implies that they are typically considered as fully disabled.

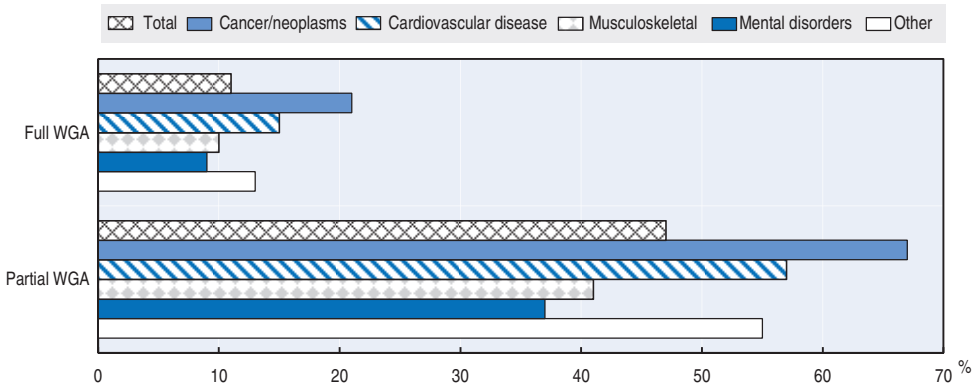
Work remains limited among disability beneficiaries

The share of WGA beneficiaries who work is much lower among people with a mental disorder than among other beneficiaries. Of those receiving a partial WGA benefit, 37% of the people with a mental disorder work compared with 47% of the total group (Figure 4.6). Among full WGA beneficiaries the percentages are respectively 9% and 11%. In sum, only 19% of the total WIA population (including both IVA and WGA) worked in 2012 (UWV, 2012b).

The lower employment rate for people with mental ill-health is related to both personal factors and work-related factors (UWV, 2013e). On the one hand, people are less likely to resume work if they have low self-esteem, multiple psychosocial problems and lack of a social network (RIVM, 2013). On the other hand, employers are less likely to retain employees with mental ill-health. A survey among 389 employers in 2010 revealed that employees with mental ill-health are much less attractive to employers than people with musculoskeletal problems, even if they function perfectly and do not need any work adjustments (Houtman et al., 2013).

Figure 4.6. **Low employment rate for WGA beneficiaries with mental ill-health**

Share of WGA beneficiaries who worked in 2012, by health condition



Source: Based on UWV (2013), *UWV Monitor Arbeidsparticipatie 2013. Aan het werk zijn, komen en blijven van mensen met een arbeidsbeperking* [UWV monitor employment rate 2013], Uitvoeringsinstituut Werknemersverzekeringen, Amsterdam.

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The good news is that the large majority of people who are working at the moment of entering the disability system also keep their job: 86% of the new partial WGA beneficiaries with a job still have it one year later

(UWV, 2013e). Very few of them use UWV support measures: only 4% of the WGA beneficiaries who were working at the end of 2012 received job coaching, a no-risk status, or other types of support, and 5% benefitted from a reintegration trajectory (see Box 4.4 for an overview of the different support measures).

Box 4.4. **UWV support measures**

Support measures for disability beneficiaries

UWV has several support measures at its disposal to promote employment among people with a work incapacity who are receiving a WIA, WAO or Wajong benefit (UWV 2013e; UWV, 2014):

- *Wage dispensation for the employer:* If granted, the employer can pay less than the legal minimum wage and this amount is topped up by UWV. Dispensation is only granted if a disability beneficiary has a lower performance than colleagues without a disability (which is assessed by UWV).
- *Employer subsidy.* Employers can obtain a subsidy for the additional costs they incur for the hiring of a disability beneficiary.
- *Trial placement.* Under this option, the employer does not have to pay a wage to the disability beneficiary for two months to give them the opportunity to find out whether the candidate is suited for the job. After that period, the employer can no longer impose a probationary period. During the two-month trial period the disability beneficiary continues receiving a disability benefit.
- *Job coach:* To get a job coach, a disability beneficiary needs to fulfil three conditions: i) unable to fulfil tasks without systematic guidance; ii) able to earn at least 35% of the legal minimum wage; and iii) have a contract for at least half a year at a regular employer (i.e. not supported employment). The support of a job coach is typically for half a year, but can be extended each time with six months for a maximum duration of three years. The maximum amount of hours decline each year.
- *No-risk polis.* A no-risk status implies that the employer does not have to pay sickness benefits in case of illness; they are paid from the collective sickness fund of UWV. Nonetheless, the employer remains responsible for the reintegration into work of the employee.
- *Support trajectories to acquire work:* In regular trajectories, a reintegration office supports the disability beneficiary for a maximum of 2.5 years in finding and retaining a job. Other possible support trajectories are education, skills training and learn-work trajectories.
- *Facilities:* Several types of facilities exist, including travel facilities, audio-visual facilities and intermediate facilities (e.g. workplace adjustments, sign language interpreter).

Box 4.4. **UWV support measures** *(cont.)*

Support measures for employers

As UWV itself cannot offer jobs to its clients and need to rely on employers for job creation, collaboration with employers is essential and has been strengthened over the past years. Especially, two support measures for employers are provided:

- *Inclusive work organisations*. These are organisations that offer jobs adjusted to the work capacity of people with disabilities. To support employers in realising an inclusive work organisation, UWV collaborated with Maastricht University in developing a method to redesign work processes (van Ruitenbeek et al., 2011). Currently, 60 UWV employment advisors have been trained as "inclusive work organisation" advisors, and they offer their services free of charge to employers who want to make their organisation accessible for people with disabilities (Wieman, 2013).
- *Employer service points.* UWV has put in place 35 regional employer service points in collaboration with municipalities and other social partners. The employer service points provide support in recruiting and selecting employees with disabilities and give advice about subsidies, support measures and financial benefits related to hiring people with disabilities (www.werk.nl/werk_nl/werkgever/direct_naar/WerkgeversServicepunt 5 September 2014).

UWV provides very little reintegration support

Employers bear the costs of the first 10 years of disability benefits through contribution premiums, but UWV is responsible for paying disability benefits and providing reintegration support. In order to encourage employers to maintain or reintegrate former employees even when they are receiving disability benefits, the contribution premiums to the WIA system depend on the share of employees that end up on disability benefits. Employers can opt out of this system by insuring their employees with a private insurer; this was the case for 27% of the employers in 2010 (Cuelenaere and Veerman, 2011).

As is the case with sick vangnetters, UWV case management for disability beneficiaries to help them returning to work is negligible, despite the long list of support measures UWV has at its disposal. Only one in four WGA beneficiaries get a reintegration *opinion* from UWV – despite the fact that 80% of new WGA beneficiaries are temporary or partially disabled – and 80% of those opinions are not followed up by a reintegration *plan* for various reasons, such as having no remaining work capacity or being too sick (Cuelenaere and Veerman, 2011). Disability beneficiaries with work capacity rely on the UWV department of public employment services to find a suitable

job (de Jong et al., 2013), but this is the department where recently all budget cuts have taken place. WIA beneficiaries who eventually found a job indicated that UWV did not play any role in the work resumption process (van der Burg et al., 2009).

Once disabled employees lose their job, their chances to find a new job (and to keep it) are as low as for disabled vangnetters. Administrative data for 2011 illustrate that about 30% of the employees whose contract was ended upon entry into the partial WGA benefit system resume work within a year; for vangnetters the share is 20% (UWV, 2013d). Yet, it turns out to be slightly easier for vangnetters on partial WGA benefits to keep their job than for previous employees in the same position; respectively 64% and 56% of them are still at work one year later.

Wajong disability benefit system

In the Netherlands, a special disability benefit scheme, Wajong, is available for people who became disabled before entering the labour market (i.e. before they turned 18 years or during their studies until age 30). The Wajong Law changed considerably in 2010 for new entrants to restrict the inflow into the system and to stimulate new beneficiaries to find and keep work (see Box 4.5), yet the beneficiaries of the old system (old Wajong) remained untouched. In 2012, there were 190 000 old Wajong beneficiaries and 36 900 new Wajong beneficiaries, together accounting for about 3.2% of the working-age population (UWV, 2012b). Every year 12 000 people between 15 and 24 enter the new Wajong system, accounting for 0.6% of the population in that age category. People can receive Wajong benefits until age 65 and more than half of the beneficiaries are older than 30 years. The Wajong benefit is requested through UWV, where an insurance physician assesses benefit eligibility.

Only a minority of the new Wajong recipients receives their benefit on the basis of a mental disorder. About 20% of the Wajong recipients have a mental disorder, whereas the majority has a development disorder (65%) (Figure 4.7, Panel A). Many Wajong recipients may have a secondary mental disorder, but no data on this is available. The administrative data of the old Wajong system do not separate intellectual disorders from mental disorders, together accounting for 73% of the total stock, slightly less than in the new Wajong system (Figure 4.7, Panel B).

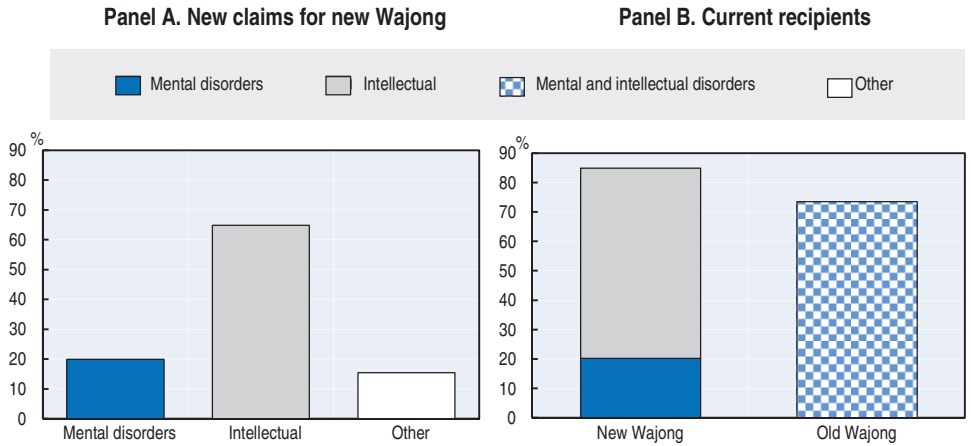
Box 4.5. **Wajong disability benefit**

People who became incapacitated before entering the labour market (i.e. before they turned 18 years or during their studies) and, in addition, are unable to earn more than 75% of the minimum wage and unlikely to fully recover within one year, are eligible for Wajong benefits (Dutch abbreviation for the Law on Work and Employment Support for Young Disabled). The Wajong benefit is a non-contributory tax-financed disability benefit. To stimulate beneficiaries to find and keep work the system changed considerably in 2010 (for new entrants only) and now consists of three different schemes:

- *Work scheme*: youth with perspectives on participating in the labour market receive employment support and a Wajong benefit equal to 75% of the (youth) minimum wage. To encourage working, Wajong beneficiaries who work and earn more than 20% of the (youth) minimum wage, can keep half of their wage on top of their benefit. Wajong beneficiaries have the obligation to accept a job offer; otherwise they risk losing their benefit.
- *Study scheme*: Students who are partially incapacitated and have not yet started working are eligible for the Study scheme and receive 25% of the (youth) minimum wage.
- *Benefit scheme*: youth without any perspectives on participating in the labour market receive a Wajong benefit equal to 75% of the (youth) minimum wage.

Figure 4.7. **One in five Wajong beneficiaries has a mental disorder**

Share of disability benefits by health condition, new claims and current recipients 2012



Note: The OECD classification of mental disorders is slightly different from the UWV classification as it excludes mental retardation, organic and unspecified mental disorders which are included under intellectual disorders.

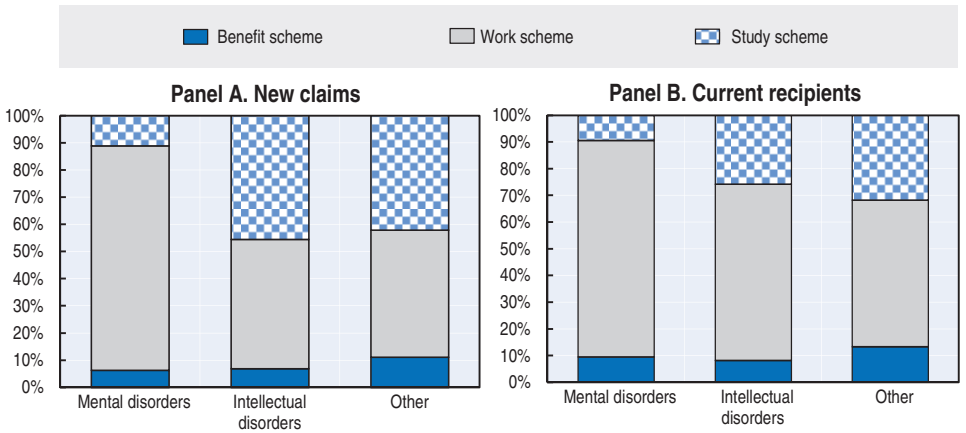
Source: OECD calculations based on data from the Employee Insurance Agency.

StatLink http://dx.doi.org/10.1787/888933145605

New Wajong beneficiaries with a mental disorder are typically placed in the work scheme (81%), much more so than among beneficiaries with other health problems (Figure 4.8). In the work scheme, people receive support in acquiring and maintaining a job until the age of 27 and they have the obligation to accept a suitable job offer, otherwise they risk losing their Wajong benefit (this seldom happens in practice; Inspectie SZW, 2012c). At the age of 27, a final judgement is made on their earning capacity and benefit eligibility (UWV, 2013e). Yet, it is too early to judge the impact of this rule since none of the beneficiaries of the new system has reached that age.

Figure 4.8. **Almost all Wajong beneficiaries with a mental disorder are in the work scheme**

Distribution of disability benefits by stream and health condition, new claims and current recipients
New Wajong, 2012



Note: The OECD classification of mental disorders is slightly different from the UWV classification as it excludes mental retardation, organic and unspecified mental disorders which are included under intellectual disorders.

Source: OECD calculations based on data from the Employee Insurance Agency.

StatLink http://dx.doi.org/10.1787/888933145617

About one in four Wajong beneficiaries (old and new system) works and the majority do so with support. In 2012, 12% of the Wajong beneficiaries worked with a regular employer and 11% in a social work provision (UWV, 2013e). Beneficiaries of the new system do hardly better than those in the old system: 32% of the new Wajong entrants in 2010 without a job at that moment found one within two years compared with 27% of those who entered the old system between 2008 and 2010. More than half (58%) of

those working have some kind of support, most often a wage dispensation or job coach. Without such support employers would not be willing to hire them (Wolf et al., 2013). Research also shows that three out of four employers organise additional internal support for Wajong beneficiaries themselves (such as support by the manager or colleagues) and two out of three adapt work (e.g. lower rhythm, fewer hours, more rest moments, and adapted tasks) (Horssen et al., 2011). Yet, keeping a job is difficult for Wajong beneficiaries: about half of them lose their job within a year (UWV, 2013e). Employers list various reasons: uncertainty about future support, too low productivity, too high need for internal support, resistance from colleagues, etc. (Wolf et al., 2013; and Horssen et al., 2011).

As a result, very few people eventually leave the Wajong scheme. In the new system, the Wajong benefit stops when a person is able to earn 75% of the minimum wage, has worked for five years and no longer needs support, or if they have earned more than 100% of the minimum wage during a year and no longer need support. Since obtaining a permanent contract and earning a market wage is not likely for Wajong beneficiaries, only 0.2% of the total caseload leaves the system with a job on a yearly basis (UWV, 2013e).

UWV support to Wajong beneficiaries mainly consists of organising workshops, job fairs and meetings, while reintegration trajectories are outsourced to private reintegration offices (UWV, 2014). In 2012, UWV financed 9 000 reintegration trajectories (24% of the new Wajong caseload); three fourth were related to placements into a job and one fourth to making the person ready for activation. UWV also developed a database with profiles of Wajong beneficiaries with information on their work capacities and interests. The database could, however, be substantially improved in terms of user-friendliness and accuracy according to the Dutch labour inspectorate (Inspectie SZW, 2012c).

So far, there is little evidence available on the effectiveness of the reintegration support for Wajong beneficiaries (Zwinkels, 2011) and it is too early to draw conclusions on the impact of the 2010 reform (SCP, 2012). In any case, as of 2015, the responsibility for new Wajong applicants who have remaining work capacity will be devolved to the municipalities (see section below including Box 4.7), which means that UWV involvement in activating Wajongers will be limited to those who entered Wajong before 2015.

Increasing responsibilities for the municipalities

People with insufficient income and wealth to support themselves who are not or no longer eligible for UWV benefits rely on their municipality for

support, as organised by the Law on Work and Assistance (Wwb). Wwb benefits are means-tested and beneficiaries are obliged to participate in reintegration activities offered by their municipality – in case of refusal, they can lose their benefits. The benefit level depends on the family situation and age of a person: a single person without children older than 21 years receives 50% of the minimum wage, 70% for those with children and 100% (together) for a couple.

In 2013, 347 100 persons under retirement age were receiving social assistance, equal to 4.4% of the labour force (CBS, 2014). At the same time, the caseload is dynamic: in 2012, 111 000 people entered the social assistance system while 96 500 left the system. Among the new Wwb entrants for whom their work or benefit history is known, 20% had a job before receiving social assistance, 31% came straight from the unemployment benefit system and 44% were not receiving any income replacement benefit in the month before their first Wwb benefit (CBS, 2013). With respect to outflow, 40% of the Wwb beneficiaries leave the system with a paid job (of which 2.3% with a wage cost subsidy) while 51% lose their entitlement due to a change in their family situation or fraud or because they reach the retirement age. A negligible share of the beneficiaries gets a Wwb benefit as a top-up to another benefit, but about 10% have some revenues from work (KWI, 2013).

Mental ill-health is common among social assistance beneficiaries

Many social assistance beneficiaries have a mental disorder, but they are not necessarily identified as such. Based on the mental health instrument in the Dutch POLS Health Survey it is estimated that 43% of the social assistance beneficiaries have a mental disorder (Figure 4.1). Yet, managers of the municipal social services responded in a survey undertaken by Divosa that only 25% of their clients have psychological barriers (Divosa, 2013a). To offer appropriate support, if necessary in collaboration with the mental health sector, a better identification of mental health problems would be necessary.

Co-operation with the mental health sector is frequent, but services are not necessarily offered in an integrated way. 88% of the social service caseworkers collaborate on an intensive or structural basis with the mental health sector (Inspectie SZW, 2012a). A few municipalities hired a mental health specialist, which allows them to better co-ordinate treatment and activation, access more easily other mental health specialists and finance part of the reintegration trajectory through their client's health insurance. In general, however, reintegration trajectories deal with a client's problems in a sequential way (i.e. one problem at the time), which significantly delays the activation process and seldom leads to a successful outcome as problems are often interlinked and should be addressed in an integrated way (Roskamp,

2013). To better co-ordinate services across sectors for clients with multiple psychosocial problems, UWV and the social and mental health services of five large municipalities started a pilot project in 2013 called Fit-4-Work (see Box 4.6 for more details). The project's goal is to reach sustainable employment (i.e. longer than one year) for at least 50% of the participants and the benefits should outweigh the costs for all involved parties.

Box 4.6. **Fit-4-work: Helping people with multiple psychosocial problems**

The pilot project Fit-4-Work is a joint initiative of UWV and the social and mental health services of five large municipalities (Amsterdam, Rotterdam, Den Haag, Utrecht and Capelle aan den IJssel) to activate benefit recipients with a large distance to the labour market due to multiple psychosocial problems. The goal is to reach sustainable employment (longer than one year) for at least 50% of the participants.

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

Fit-4-Work is a randomised control trial built on national and international experiences with multidisciplinary integration approaches, including the ExIT project in Rotterdam and the WeCare project in New York. An evaluation of the ExIT approach showed an outflow to work of 40% of the participants compared with 13% of the control group which followed a regular trajectory (Jagmohansingh, 2008).

The pilot project is financed by the involved parties and subsidised by the government, but an ex-ante cost-benefit analysis shows that the benefits should outweigh the costs for all involved parties within four years. The approach is executed by a private reintegration office (selected through a tender process), which is paid 75% of the budget after a client is placed in a job for more than one year. The remaining 25% is only paid if at least 50% of the participants are still in employment after four years.

Source: Kok, L. et al. (2011), "Fit-4-Work: een ex-ante kosten-baten analyse" [Fit-4-Work: an Ex-ante Cost-benefit Analysis], SEO Economisch Onderzoek, Amsterdam; van Dijk, K. and R. van Rijn (2013), "Fit4Work: Mensen met psychosociale klachten en multiproblematiek begeleiden naar werk" [Guiding people with psychosocial complaints and multiple problems to work], in SZW (2013), Gezond aan het werk: Samenwerken aan gezondheidsbevordering en participatie van mensen in de bijstand, Expertmeeting 30 januari 2013, Ministerie van Sociale Zaken en Werkgelegenheid, Den Haag.

The impact of the Participation Law

A new law, the Participation Law (see Box 4.7 for more details), intends to extend the responsibilities of the municipalities to a larger group of clients – the implementation of the law is foreseen for 1 January 2015. The Participation Law will group three different regulations into a single one: social assistance benefits regulated by the Law on Work and Assistance (Wwb), entitlements to a social work place regulated by the Law on Social Work Provision (Wsw), and disability benefits regulated under Wajong (see above). The idea behind the reform is that: i) clients of the three regulations all have severe difficulties to enter the labour market; and ii) the municipalities are better placed than UWV to offer integrated reintegration support for these groups (KWI, 2013 and Centraal Planbureau, 2013). In practical terms, the introduction of the Participation Law will increase the number of people relying on the municipalities further, though less than initially foreseen (see also SZW, 2012).

Along with increased responsibility, the reintegration budgets available to the municipalities have been decreasing significantly since 2010. Municipalities receive a participation budget from the state to fund reintegration and participation measures for their clients, with the budget amount depending on the population composition and the labour market situation. Yet, while the number of social assistance beneficiaries has been increasing continuously since 2008 (about 30% between 2008 and 2012), the participation budget that municipalities have at their disposal has more than halved between 2010 and 2013 (Divosa, 2013b). As a result of these cuts, municipalities reduced expensive wage subsidies and subsidised employment, and focused instead on classical reintegration measures (such as coaching, job mediation, courses and training). They also further limited the outsourcing of reintegration trajectories; the market share of private reintegration services dropped from 41% in 2009 to 33% in 2012.

The significant decrease in the available budget per client raises the question whether the municipalities will be able to deliver appropriate support to their existing as well as new clients.

Box 4.7. **The Participation Law**

The Participation Law groups three different regulations into a single one: social assistance benefits, entitlements to a social work place, and disability benefits for young people. The municipalities will become responsible for the benefit provision and labour market integration of these groups as of 1 January 2015.

Impact on Wajong

Eligibility will be restricted because new applicants with remaining work capacity will no longer be eligible for Wajong benefits. They can instead apply for social assistance at the municipalities. People who entered the Wajong system before 2015 will not be transferred to the municipalities and keep their Wajong benefit, as well as new applicants who will never be able to work because of their disability. This means that UWV involvement in activating Wajongers will be limited to disabled youth who entered the system before 2015, whereas municipalities will be responsible for youngsters with remaining work capacity.

The government estimates that 60% of the current Wajong beneficiaries have remaining work capacity, whereas 40% will never be able to work. As of 2018, the benefit level of Wajongers with remaining work capacity will be decreased from 75% to 70% of the minimum wage to increase the incentive for this group to seek work.

Support measures

Municipalities will receive one single budget and are free to determine who gets which support. They have several new support measures at their disposal, including a (structural) wage cost subsidy, employer exemptions for sick-pay costs ("no-risk polis"), sheltered employment and other work-provision measures (mainly job coaches, but also job adaptation, transport to the workplace and other measures).

Job creation linked with the Participation Law

Social partners and the government agreed to create 125 000 extra jobs for people with disabilities by 2026 (100 000 in the private sector – including sheltered employment – and 25 000 in the public sector). The government threatens with a quota imposition in case of insufficient effort by the parties involved; a first evaluation will take place in 2015. Wajong beneficiaries, together with people entitled to a social work place, will get priority for the extra jobs that are going to be created in the regular job market.

Source: SZW (2013), Kamerbrief Participatiewet en quotum: toezeggingen, 2 December 2013, Ministerie van Sociale Zaken, Den Haag. www.rijksoverheid.nl/onderwerpen/re-integratie/nieuws/2013/12/02/participatiewet-opent-deuren-naar-arbeidsmarkt-voor-mensen-met-beperking.html (accessed 10 April 2014); SZW (2014) , Kamerbrief overzicht verschillen Wet Werken naar Vermogen en Participatiewet, 10 maart 2014, Ministerie van Sociale Zaken, Den Haag, www.rijksoverheid.nl/onderwerpen/wajong/documenten-en-publicaties/kamerstukken/2014/03/10/kamerbrief-overzicht-verschillen-wet-werken-naar-vermogen-en-participatiewet.html (accessed on 16 September 2014).

First, municipalities have no financial incentives to support people who are not entitled to social assistance benefits and the budget restrictions further reduce the likelihood that they will do so. Indeed, three out of four municipalities intend to limit their support for people who are not receiving any benefit due to the decrease in resources (Divosa, 2011). This is particularly bad news for disabled youth with remaining work capacity who are still living at home, because social assistance benefits are means tested and depend on the household income and wealth. These youngsters are thus unlikely to receive financial or reintegration support from the municipalities. Given their significant labour market disadvantages, it is unlikely that they will manage to find a job without support, which increases the risk of full and permanent work incapacity and the chances to end up on Wajong benefits eventually.

Second, it is unclear whether municipalities really have the appropriate means and knowledge to activate clients with severe labour market disadvantages and in particular those with multiple psychosocial problems. The underlying reason for the Participation Law is that municipalities are better placed to support such clients and that they will do so more efficiently. Yet, as discussed above, municipalities seldom offer integrated multidisciplinary support. In addition, Zwinkels (2011) argues that part of the municipalities' successes in the past decade in terms of increased outflow was reached through a focus on clients with better chances (especially youth and people with a benefit history of less than one year) and a shift of youth with disabilities onto the Wajong benefit system.

Third, the reintegration of clients with severe labour market disadvantages is currently often outsourced to private reintegration offices. UWV, as a national player, has the advantage of buying services from private reintegration offices in large quantities and can negotiate down the price (Zwinkels, 2011). Indeed, Veldhuis and Veerman (2011) mention that 95% of all private reintegration offices have worked at least once for UWV and 50% depended for more than half of their business on UWV in 2009. Municipalities do not have this benefit of scale and recently have been limiting the outsourcing of reintegration trajectories as they were too expensive (Divosa, 2013a). It will thus be necessary for municipalities to develop strategies for the reintegration of clients with severe labour market disadvantages in-house.

The municipalities can nevertheless build on the existing knowledge and facilities that UWV and others have developed in recent years, for instance the employer service points (see Box 4.4) and the Wajong database with information on their work capacities and interests. In addition, the Dutch federation of municipality managers responsible for participation, work and income (Divosa) developed a range of

guidelines and factsheets on best practices (see Box 4.8). Yet, they provide little information on how to co-operate with other sectors, in particular the mental health sector, or how to offer integrated services. Finally, to further encourage sharing of best practices, the Netherlands could adopt the Danish approach where municipal efforts are monitored through publicly available databases on the programmes used for different clients (*Jobindsats*) and the cost-effectiveness of these programmes (*Effektivindsats*) (OECD, 2013b).

Box 4.8. **Divosa shares and distributes knowledge and information across municipalities**

To support the municipalities in the ongoing and upcoming reforms and to share knowledge and information to improve municipal activation policies, the Dutch federation of municipality managers responsible for participation, work and income (Divosa) developed a range of guidelines and factsheets of best practices.

For instance, Divosa prepared guidelines for caseworkers on how to approach employers for job creation for their clients (Divosa, 2013c). Another example is an overview of the screening instruments used across municipalities to identify their clients' strength and weaknesses to resume work and possible activation measures (Divosa, 2013d). Finally, Divosa also constructed a website with an overview of existing knowledge (national and international) on the effectiveness of different reintegration strategies.*

The guidelines and factsheets build as much as possible on evidence-based practices, combined with practice-based experiences in the different municipalities.

* http://interventiesnaarwerk.nl/ (accessed 12 September 2014).

Conclusions and recommendations

Activation policy in the Netherlands is undergoing important and far-reaching reforms, affecting the majority of benefit recipients, ranging from unemployment beneficiaries, to sick vangnetters and social welfare recipients. In short, UWV support services for jobseekers are digitalised, financial incentives for UWV clients and employers are strengthened, and the municipalities are getting more responsibilities. Only the support role of UWV remains largely unaddressed, while this is probably the weakest part in the entire activation chain for people with mental ill-health. In particular, UWV is unaware of the large share of mental disorders among unemployment beneficiaries and the needs of this group, and it does not offer appropriate sickness management to jobseekers who are temporarily too sick to work due to their mental health problem. Given the importance of early intervention for people with a mental disorder, more attention should

be devoted to this group, ideally in close co-operation with mental health specialists.

The strategy of UWV to fully digitalise support for jobseekers is new and innovative. Benefitting from experience with and knowledge on e-services in the health sector, communication science, marketing and social psychology, the digital system of UWV could potentially become a powerful tool to activate jobseekers, including those with mental health problems. Yet, it is crucial that the system is developed in a thorough way and finalised as soon as possible. Otherwise the short term cost savings for UWV may have huge implications for other parts of the social welfare system, especially for the sickness and disability system and for social assistance provided by the municipalities.

Insufficient sickness management support for vangnetters is a major concern since these people typically have a lower socio-economic status and worse health than permanently employed workers, and are thus in more need of appropriate and prompt case management. Yet, contrarily to sick employees, sick vangnetters seldom receive timely support as UWV waits until they are bettered and have work capacity to set up an action plan. Even so, research has shown that employment and mental health are interlinked and that work fastens the recovery process. Co-operation with mental health specialists is thus of paramount importance to fasten reactivation.

An upcoming reform will devolve the responsibility for disabled youth with remaining work capacities (who are no longer eligible for Wajong benefits) to the municipalities, building on the idea that the latter are better placed to offer integrated support in co-operation with the education, mental health and care sector. This may well be true, but developing such integrated approach takes time and the combination of a reduction in resources and an increase in caseload will significantly affect the support municipalities can give to their existing clients in the short run. Many of these clients have mental health problems and are in need of intensive support to enter the labour market. Failing to deliver appropriate support may – again – have long-term implications for other systems, including the mental health sector and the disability benefit system.

Optimise the digital support system for jobseekers

- *Identify mental health problems early on and provide targeted support.* The digital questionnaire "work explorer" is an ideal opportunity to systematically assess the mental health status of jobseekers and to offer targeted support before a jobseeker claims sickness benefits. The questionnaire could be extended to integrate a validated instrument for the identification of mental ill-health

among jobseekers. Internet-administered cognitive behaviour therapy for depression and anxiety and other digital therapies should be integrated in the digital support programmes of UWV.

- *Combine digital therapies with face-to-face support.* Digital therapies for mental health problems work best if they are combined with face-to-face contact. Personal support should not only be available for those who are sick. If psychosocial problems are identified by the work explorer, appropriate support in co-operation with the mental health sector should be offered even before the jobseeker falls sick.
- *Closely monitor the long-term impact of the digitalisation of UWV support.* Insufficient or inappropriate support in the early phase of unemployment quickly reduces reintegration chances of jobseekers and could trigger long-term labour market withdrawal.

More and better support for sickness and disability beneficiaries

- *Improve pro-active support.* UWV primarily focuses on stimulating sick vangnetters and disability beneficiaries to find work. However, these clients are in a vulnerable position and therefore less attractive for employers, making it very hard to find work themselves. Sickness and disability management by UWV could be improved by more pro-active support, for example, through job coaching and active recruitment into trial jobs targeted at these groups.
- *Ensure continuity in support.* Communication between divisions within UWV and continuity of support needs to be safeguarded for workers who move through different divisions depending on their health status (e.g. unemployed people move to a different division when they become sick).
- *Provide timely support to all sickness and disability beneficiaries.* Too few sickness beneficiaries and temporary or partial disability beneficiaries are currently benefiting from UWV support. UWV should be legally obliged to set up a reintegration plan within eight weeks for *all* clients, even if they are temporarily too sick to work. In that case, treatment and close co-operation with mental health specialists should be an integral part of the reintegration plan. The recent covenant between UWV and GGZ is an excellent starting point to develop collaboration strategies. Psychological training for all UWV caseworkers will also be crucial.

Strengthen the responsibility of the UWV

- *Invest in early co-operation with the municipalities.* Many clients of UWV have psychosocial problems which form a major barrier for returning to work, such as mental ill-health, debt problems and substance abuse. UWV should invest more to address these problems and not wait until clients get off their benefit roll and rely on the municipalities for support.
- *Introduce financial incentives for UWV to improve sickness management.* While employers are facing a strong financial incentive to invest in work resumption of sick or disabled employees (they have to finance a third year of sick pay in case of insufficient reintegration efforts), this is not the case for UWV. The costs of inappropriate management by UWV are borne by the individual and the municipalities (in case they are eligible for social assistance).
- *Expand the use of the digital support system.* The digital support system developed by UWV could be useful for other parts of the system, especially municipalities, to screen their clients and offer targeted support. Potentially, also people who are still in employment and who need advice or support to keep their job or seek a new one could benefit from the digital support programmes.
- *Improve reintegration supports for Wajongers*. With the latest reform it was decided that all current Wajongers will remain under the responsibility of the UWV. Wajongers with work capacity would benefit from more effective reintegration trajectories with better-integrated health and work support, since very few people ever leave the Wajong scheme.

Ensure that the municipalities can deliver good outcomes

- *Develop integrated support in co-operation with the mental health sector.* Many social assistance clients have multiple psychosocial problems which are interlinked and significantly affect their work capacity. It is crucial for the municipalities to develop their expertise to deliver multidisciplinary services in an integrated way and in close co-operation with the mental health sector. The knowledge obtained from the pilot projects Exit and Fit-4-work should be shared with all municipalities and resulting lessons implemented as quickly as possible.

- *Monitor municipal efforts with a transparent database on outcomes and tools applied.* Systematic monitoring and benchmarking of outcomes at the municipal level (like in Denmark) would allow municipalities to compare outcomes and learn from better performers.
- *Encourage municipalities to support all clients, not only those receiving benefits.* Due to budgetary restrictions municipalities are unlikely to offer support to disabled youth with remaining work capacities not eligible for social assistance (for instance, those living with their parents). Given their complex needs, it is unlikely that these youngsters could find and keep a job without support.
- *Scale up resources if necessary.* The resources currently available to the municipalities may be insufficient to bring clients into work. As soon as the tight budget situation allows, municipal reintegration resources should be scaled up if necessary. Otherwise savings at the municipal level might merely lead to higher spending in other parts of the social welfare system.

Notes

1. Survey data, as opposed to administrative data, also capture undiagnosed mental health problems and mental disorders as secondary conditions, which explains the difference in the mental health share with respect to the share calculated based on administrative data in Chapter 1.
2. Workers who benefit from the "no-risk status" for which UWV bears the full costs of illness are also covered by the collective sickness fund.
3. The reported percentage may be an underestimation as vangnetters do not necessarily know or remember that these documents have been drawn up. Even so, this fact would signal the need for better communication and involvement of vangnetters in the problem analysis and work plan.

References

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

Berendsen, E. (2012), "Overgangen binnen de WIA, Kennismemo 12/02" [Transitions within the WIA, knowledge memo 12/02], Uitvoeringsinstituut Werknemersverzekeringen, Amsterdam.

Bijlert, J., K. Bongers, and H. Goossensen (2012), *Gedragsbeïnvloeding in een online omgeving. Een verkennende literatuurstudie naar de mogelijkheden van online gedragsbeïnvloeding toegepast op UWV* [Influencing Behaviour in an Online Environment: an Exploratory Literature Study on the Possibilities of Influencing Behaviour Online Applied to UWV], Centrum voor Criminaliteitspreventie en Veiligheid, Utrecht.

Brouwer, S. et al. (2011), *Eindrapportage voorspellers van werkhervatting. Een onderzoek onder werklozen in Noord-Holland* [Final Report on Predictors of Work Resumption: Research Among Unemployed in Noord-Holland], Rijksuniversiteit Groningen UMCG/UWV Kenniscentrum, Groningen/Amsterdam.

Buijsman, C. and A. Pepping (2012), *Wet beperking ziekteverzuim en arbeidsongeschiktheid 'vangnetters'* [Act on Restricting Sickness Absence and Work Disability Among 'Vangnetters'], Nieuwsflits Boekel de Néree, Amsterdam.

CBS (2014), "StatLine", Centraal Bureau voor de Statistiek, http://statline.cbs.nl/StatWeb/ (accessed 04 April 2014).

CBS (2013), *Labour Market Policy Database*, Centraal Bureau voor de Statistiek, Den Haag.

Centraal Planbureau (2013), "Decentralisaties in het sociaal domein. Uitgevoerd op verzoek van de ministeries van Binnenlandse Zaken en Koninkrijkrelaties, Financiën en de Vereniging van Nederlandse Gemeenten" [Decentralisation in the social domain. Conducted on request of the ministry of the Interior and Kingdom Affairs and the Association of Dutch Municipalities], *CPB Notitie*, 4 September 2013, Den Haag.

Cuelenaere, B. and T. Veerman (2011), *Onderzoek evaluatie WIA* [Research Evaluation of WIA], AStri Beleidsonderzoek en -advies, Leiden.

Cuijpers, P., A. Van Straaten and G. Andersson (2008), "Internet-administered Cognitive Behavior Therapy for Health Problems: A Systematic Review", in M. Sorbi and H. Riper (eds.), "E-Health – gezondheidszorg via internet", *Psychologie & Gezondheid*, Vol. 37, No. 4, pp. 191-201.

de Jong, P., T. Everhardt and C. Schrijvershof (2013), "Duurzaam niet-duurzaam? Onderzoek naar niet-duurzaam volledig arbeidsongeschikt verklaarden" [Sustainable or non-sustainable? Research on those deemed temporarily completely work disabled], Aarts De Jong Wilms Goudriaan Public Economics bv (APE), Den Haag.

de Jong, P. et al. (2010), *Nederland is niet meer ziek: Van WAO-debakel naar WIA-mirakel* [The Netherlands is No Longer Sick: From WAO-Bebacle to WIA-miracle], APE/AStri Beleidsonderzoek en -advies.

de Jong, P., C. Schrijvershof and T. Veerman (2009), "Langdurig verzuim van vangnetters" [Long-term sickness absence of vangnetters], *Economisch Statistische Berichten*, Vol. 94, No. 4563, pp. 407-409.

Divosa (2013a), "Divosa-monitor factsheet: In-en uitstroom uit de bijstand 2012" [Divosa-monitor factsheet: inflow and outflow from social assistance 2012], Utrecht.

Divosa (2013b), "Divosa-monitor factsheet: Participatiebeleid 2012"[Divosa-monitor factsheet: participation policy 2012], Utrecht.

Divosa (2013c), "Werkwijzer Werkgeversdienstverlening" [Work procedure: Service provision for employers], Utrecht.

Divosa (2013d), "Werkwijzer Diagnose-instrumenten" [Work procedure: Diagnostic instruments], Utrecht.

Divosa (2011), "Grenzen verleggen. Sociale diensten en participatiebevordering" [Moving the boundaries. Social services and improving participation], Divosa-monitor 2011 – deel 1, Utrecht.

Horssen, C., M. van Blommesteijn and F. Rosing (2011), *Een Wajonger in mijn bedrijf?! Een onderzoek naar de attitude, ervaringen en bereidheid van werkgevers om een Wajonger in dienst te nemen en te houden* [A Wajonger in My Company?! Research on the Attitude, Experiences and Willingness of Employers to Hire and Keep a Wajonger], Regioplan Beleidsonderzoek, Amsterdam.

Houtman, I., L. Koppes and F. Dekker (2013), "Verklaring van de stijging in WIA-instroom: Een werknemers- en werkgeversperspectief" [Explanation of the increase in the WIA-inflow: an employee and employer perspective], TNO, Leiden.

Inspectie SZW (2012a), "Vraaggerichte dienstverlening voor vangnetters" [Demand-driven service provision for vangnetters], Ministerie Sociale Zaken en Werkgelegenheid, Den Haag.

Inspectie SZW (2012b), "Samen de focus op werk. Een landelijk beeld van de samenwerking tussen professionals werk en inkomen en de gezondheidszorg" [Focussing on work together: A national picture of the collaboration between professionals work and income and the health care system], Ministerie Sociale Zaken en Werkgelegenheid, Den Haag.

Inspectie SZW (2012c), "Tussen Wajong en werk. Het vinden van de juiste" werkplek [Between Wajong and work: finding the right workplace], Ministerie Sociale Zaken en Werkgelegenheid, Den Haag.

Jagmohansingh, S. (2008), "Evaluatie ExIT Feijenoord" [Evaluation ExIT Feijenoord], Sociale Zaken en Werkgelegenheid, Rotterdam.

KWI (2013), "Investeren in Participeren. Kennis voor de uitvoering van werk en inkomen" [Investing in participation. Knowledge for the execution of work and income], Kennisplatform Werk en Inkomen.

Kok, L. et al. (2011), *Fit-4-Work: een ex-ante kosten-baten analyse* [Fit-4-Work: an Ex-ante Cost-benefit Analysis], SEO Economisch Onderzoek, Amsterdam.

OECD (2014), *Ageing and Employment Policies: Netherlands 2014. Working Better with Age*, OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264208155-en.

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

OECD (2013b), *OECD Employment Outlook 2013*, OECD Publishing, Paris, http://dx.doi.org/10.1787/empl_outlook-2013-en.

OECD (2012), *Sick on the Job? Myths and Realities about Mental Health and Work*, OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264124523-en.

OECD (2011), *OECD Employment Outlook 2011*, OECD Publishing, Paris, http://dx.doi.org/10.1787/empl_outlook-2011-en.

RIVM (2013), *Gezondheid en maatschappelijke participatie. Themarapport Volksgezondheid Toekomst Verkenning 2014* [Health and social participation: Theme Report Public Health Future Exploration 2014], Rijksinstituut voor Volksgezondheid en Milieu, Bilthoven.

Roskamp, H. (2013), "Fit4Work", *UWV Magazine*, No. 4, Amsterdam.

SCP (2012), *Belemmerd aan het werk* [Working with a Disability], Sociaal Cultureel Planbureau, Den Haag.

SZW (2014), Kamerbrief overzicht verschillen Wet Werken naar Vermogen en Participatiewet, 10 maart 2014 [Overview of of the differences between Wet Werken naar Vermogen and Participatiewet], Ministerie van Sociale Zaken, Den Haag, www.rijksoverheid.nl/onderwerpen/wajong/documenten-en-publicaties/kamerstukken/2014/03/10/kamerbrief-overzicht-verschillen-wet-werken-naar-vermogen-en-participatiewet.html (accessed on 16 September 2014).

SZW (2013), "Kamerbrief Participatiewet en quotum: toezeggingen, 2 December 2013" [Letter to the parliament on the Participation Law and quota: commitments, 2 December 2013], Ministerie van Sociale Zaken, Den Haag, www.rijksoverheid.nl/onderwerpen/re-integratie/nieuws/2013/12/02/participatiewet-opent-deuren-naar-arbeidsmarkt-voor-mensen-met-beperking.html (accessed 10 April 2014).

SZW (2012), *Contouren Participatiewet* [Outlines of the Participation Act], Ministerie van Sociale Zaken en Werkgelegenheid, Den Haag.

UWV (2014), Ingekochte re-integratiedienstverlening Wajong [Purchased reintegration support Wajong], Uitvoeringsinstituut Werknemersverzekeringen, Amsterdam.

UWV (2013a), Kwantitatieve informatie 2013 [Quantitative information 2013], Uitvoeringsinstituut Werknemersverzekeringen, Amsterdam.

UWV (2013b), UWV Achtmaandenverslag 2013 [UWV eight-month report 2013], Uitvoeringsinstituut Werknemersverzekeringen, Amsterdam.

UWV (2013c), UWV Kennisverslag 2013-2 [UWV Knowledge report 2013-2], Uitvoeringsinstituut Werknemersverzekeringen, Amsterdam.

UWV (2013d), UWV Kennisverslag 2013-1 [UWV Knowledge report 2013-1], Uitvoeringsinstituut Werknemersverzekeringen, Amsterdam.

UWV (2013e), UWV Monitor Arbeidsparticipatie 2013 [UWV Monitor employment rate 2013], Uitvoeringsinstituut Werknemersverzekeringen, Amsterdam.

UWV (2012a), UWV Kennisverslag 2012-2 [UWV Knowledge report 2012-2], Uitvoeringsinstituut Werknemersverzekeringen, Amsterdam.

UWV (2012b), Kwantitatieve informatie 2012 [Quantitative information 2012], Uitvoeringsinstituut Werknemersverzekeringen, Amsterdam.

van der Burg, C. et al. (2013), *Weg naar de WIA: Langdurig zieken 2012* [Road to the WIA: Long-term Sick 2012], AStri Beleidsonderzoek en -advies, Leiden.

van der Burg, C. (2011), "Profilering langdurig zieke vangnetters: Kenmerken en begeleiding van de vangnetpopulatie op basis van dossieronderzoek" [Profiling long-term sick vangnetters: Characteristics and guidance of the vangnet population following dossier research], AStri Beleidsonderzoek en -advies, Leiden.

van der Burg, C., D. Arts and V. Veldhuis (2009), "Begrip en beleving van de WGA. Ervaringen van WGA-cliënten met de WGA" [Understanding and experience of the WGA. Experiences of WGA-clients with the WGA], AStri Beleidsonderzoek en -advies, Leiden.

van der Hoek, W. et al. (2008), "De vangnetpopulatie in de Ziektewet: Kenmerken en risicofactoren voor langdurig verzuim" [The vangnet population supported by the collective sickness fund: Characteristics and risk factors of long-term sickness absence], *Tijdschrift voor Bedrijfs- en Verzekeringsgeneeskunde*, Vol. 16, Issue 6, pp. 240-246.

van Dijk, K. and R. van Rijn (2013), "Fit4Work: Mensen met psychosociale klachten en multiproblematiek begeleiden naar werk" [Guiding people with psychosocial complaints and multiple problems to work], in SZW (2013), *Gezond aan het werk: Samenwerken aan gezondheidsbevordering en participatie van mensen in de bijstand, Expertmeeting 30 januari 2013*, Ministerie van Sociale Zaken en Werkgelegenheid, Den Haag.

van Rens, C., S. Oomens and N. van Kessel (2012), "Toegankelijkheid van de e-dienstverlening WW van UWV" [Accessibility of the e-service WW from UWV], ITS, Radboud Universiteit Nijmegen.

Van Ruitenbeek, G. et al. (2011), "Handboek arbeidsanalyse en herontwerp van werkprocessen: Onderdeel van de UM/UWV-methode Inclusief herontwerp van werkprocessen" [Manual work analysis and redesign of work processes: Part of the UM/UWV-method Inclusive redesign of work processes], Adviesdeskundig Kennis Centrum, Nijker.

Venn, D. (2012), "Eligibility Criteria for Unemployment Benefits: Quantitative Indicators for OECD and EU Countries", in *OECD Social, Employment and Migration Working Papers*, No. 131, OECD Publishing, Paris, http://dx.doi.org/10.1787/5k9h43kgkvr4-en.

Veldhuis, V. and T. Veerman (2011), "De markt beweegt verder: Ontwikkelingen aan de aanbodzijde van de re-integratiemarkt" [The market moves on: Developments within the supply side of the reintegration market], AStri Beleidsonderzoek en -advies, Leiden.

Wieman, D. (2013), "'All inclusive' is geen luxe maar noodzaak" ['All inclusive' is not a luxury but a necessity], *Advisie,* pp. 6-9.

Wolf, E., S. De Visser and M. Engelen (2013), Pilots werken naar vermogen: Een samenvattend rapport [Pilot on work capacity. A summary report], Panteia, Zoetermeer.

Zwinkels, W. (2011), "Verwachte effecten overheveling Wajong naar gemeenten" [Anticipated effects of transferring Wajong to municipalities], Epsilon research, Leiden.

Chapter 5

The role of the Dutch health care sector in improving mental health and work outcomes

This chapter looks at the role of the mental health care sector in the Netherlands. It assesses the effectiveness of the mental health care sector in providing adequate treatment to people with mental disorders and discusses the new health care reform that has increased responsibilities for general mental health care to alleviate the treatment burden on specialised mental health care. Finally, it reviews the difficulties of integrating mental health care and employment services in the Netherlands due to the segregation of mental health care and occupational health care services.

Adequate treatment of mental disorders is essential to prevent a chronic discourse that can cause permanent disability and incapacity to work. Early identification and treatment of mental disorders can only be ensured when sufficient mental health care services are available and accessible to all people. In the Netherlands, only a minority of people with mental health problems receive treatment. Many of them are directly referred to second-line (specialised) mental health care, putting a great burden on this system. Addressing the impact of mental health problems on work participation is of paramount importance to sustain work capacity. This asks for a proper integration of mental health care and employment support services, which is rare today. These challenges are elaborated below.

Treatment of mental health problems

Evidence on limited mental health treatment

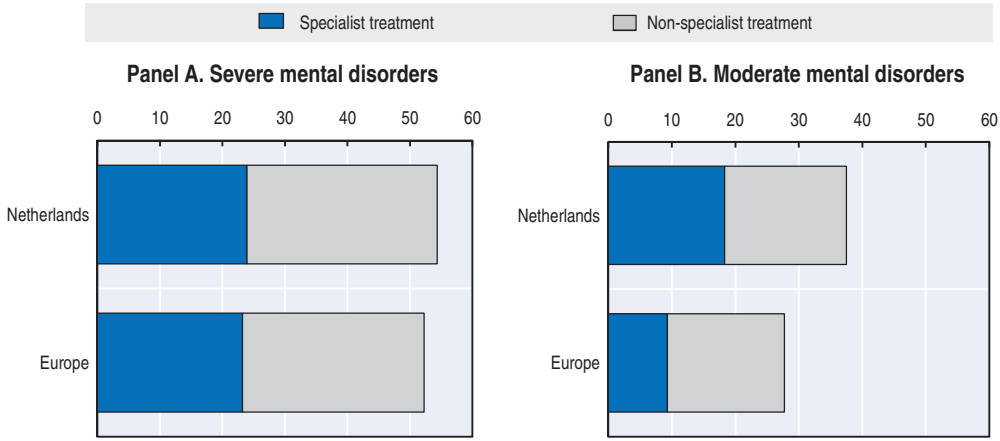
In the Netherlands, general practitioners (GPs) are the gatekeepers of mental health care and play an important role in recognising and treating mental health problems. The majority of people with mental health problems who visit their GP are also treated by the GP for these problems. Data from the Netherlands Information Network of General Practice (LINH) show that in 2010 only 16% of the patients diagnosed with mental health problems were referred by their GP to first-line mental health care (i.e. treatment provided by first-line psychologists) or second-line mental health care (i.e. specialised mental health care, including in-patient care) (Trimbos-instituut, 2012a). Data from the Eurobarometer confirm that a minority of people receive specialised mental health care in the Netherlands; only 24% of the adults with severe mental health problems and 18% with moderate mental disorders were treated in specialised mental health care (see Figure 5.1.). However, this does not necessarily mean that the remaining percentage of untreated people would have needed or wanted specialised treatment (OECD, 2012). For example, data from a household survey among 6 646 participants by de Graaf, ten Have and van Dorsselaer (2010) showed that only 8.7% and 5.9% of the participants with a diagnosed mood disorder and anxiety disorder, respectively, reported an unmet need of care. However, no data is available on the unmet needs for mental health treatment among the general population (including people with sub-threshold symptoms).

While the treatment rate among people with severe problems is similar to the OECD average, the rate of people with moderate mental health problems that is treated in specialised care is significantly higher in the Netherlands than the average OECD country (see Figure 5.1). This might be due to the good availability and visibility of mental health care. In 2009,

there were about 4 000 first-line mental health care providers (Trimbos-instituut, 2012a) and at that time the patient population consisted of 91 000 (i.e. a theoretical caseload of about 23 patients per specialist). Also, second-line mental health care has become more visible since the changes in the health insurance system (see below), which resulted in a growing market of second-line mental health care institutes.

Figure 5.1. **Only a minority of people with a mental disorder are treated**

Share of people who sought treatment for their mental illness in the past three months, y severity of the disorder and type of treatment,[a] the Netherlands versus Europe, 2010



Note: Europe is an unweighted average of 21 European countries.

a. "Specialist" includes psychiatrist, psychologist, psychotherapist or psychoanalyst. "Non-specialist" includes general practitioner, pharmacist, nurse, social worker or "someone else".

Source: OECD calculations based on Eurobarometer 2010.

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On average, people wait relatively long before looking for treatment. Research has shown that the time between onset of a mental disorder (according to one's own assessment) and the first treatment contact with any kind of treatment provider varies between three to six years for people with mood or anxiety disorder (ten Have et al., 2012).

Reasons for limited treatment in mental health care

Why half of the people with a severe mental disorder and two third of those with a moderate disorder do not receive any treatment is not straightforward but might be partly explained by four factors. First, GPs

could under-diagnose mental health problems. No recent Dutch studies are available that have compared diagnoses by GPs versus psychiatrists or psychologists. However, comparing the 2010 LINH data showing that GPs diagnose 12% of their patients with a mental health problem, with the yearly prevalence of mental disorders of 18% found by de Graaf et al. (2010), seems to suggest that there is at least some under-diagnosing by GPs.[1] This comparison will most likely be an underestimation of under-diagnosing as the yearly 18% prevalence is based on the general population and will probably be higher for the population visiting a GP.

Second, both in first-line and second-line mental health care, about a third of the patients have longer waiting times than deemed acceptable according to national guidelines set by mental health care providers and health insurance companies (so-called "Treeknormen"). In first-line mental health care, 30% of the patients have to wait longer than three weeks before the first consultation. In second-line mental health care, 25% and 32% of the patients need to wait longer than four weeks for the intake and diagnosis, respectively, and 23% need to wait longer than six weeks before the start of treatment (Verbeek et al., 2011).

Third, people could refrain from looking for mental health treatment as there is a compulsory own risk clause of EUR 360, meaning that all health care costs (i.e. not only mental health care costs) up to this amount are not reimbursed. A study by Koopmans and Verhaak (2012) showed that the potential introduction a premium for specialised care influences a patient's intention to use care. They asked 4996 patients with a DSM IV diagnosis and treated in second-line mental health care whether they would continue to use specialised care if they had to pay an amount of EUR 100, 200 or 420 themselves. The results showed that at an amount of EUR 200, among the 89% who responded, 40% would stop using care and 30% would reduce care use (for EUR 100, this was 20% and 26%). At an amount of EUR 420, 72% replied that they would stop using care. Although this study only looked at patients' intentions, not actual behaviour, and was focused on a premium for mental health care specifically while the own risk clause is for all type of health care costs, it indicates that patients with serious complaints might miss out on necessary treatment due to compulsory co-payments.

Fourth, stigma related to having a mental disorder might prevent people from seeking treatment. Although stigma seems to be less persistent in the Netherlands compared to other OECD countries (OECD 2012), strong prejudices exist especially in relationship to work participation. For example, research has shown that employers think that workers with mental disorders hamper the work/production process and cannot take responsibilities (Kolenberg, 2012). Moreover, out of a panel of approximately 800 people with mental disorders, 37% reported being

discriminated or neglected because of their mental disorder (of which 45% experienced this regularly or often) (Overweg and Michon, 2011). Nevertheless, research by Laitinen-Krispijn and Bijl (2002) shows that people on sickness absence for purely mental health problems are more likely to look for treatment than those with somatic health problems or a combination of both. In 2011, several institutions (among others, the national organisation for clients, the Dutch Association of Mental Health and Addiction Care and the Foundation Mental Health) founded the foundation "Together Strong Against Stigma" to collaborate on anti-stigma campaigns (Kolenberg, 2012).[2]

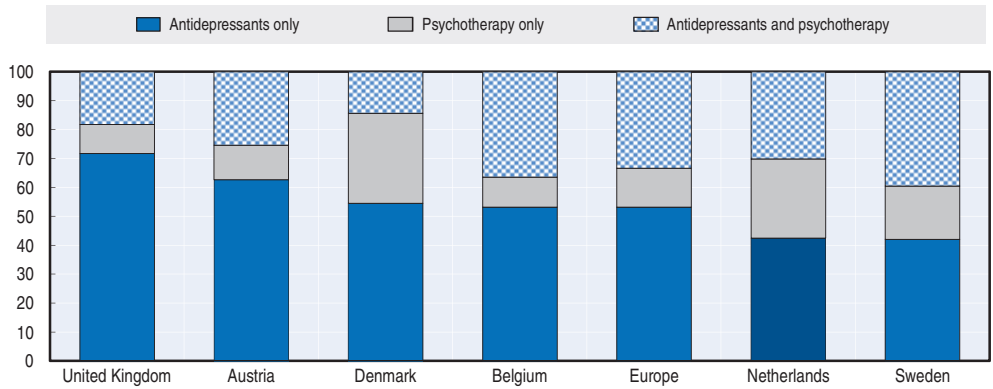
Type of treatment

Among those people receiving treatment for their mental problem, the use of psychotherapy is widespread. While antidepressant medication has risen by more than 80% between 1996 and 2011 (Verbeek et al., 2011), the prescription of antidepressants is lower in the Netherlands than in other European countries and the use of psychotherapy is more common (see Figure 5.2.). In 2010, 65% of the patients diagnosed with a mental disorder received some kind of psychotropic medication from the GP. Within first-line mental health care, psychotropic medication is rarely prescribed; only 18% of the patients receive psychotropic medication and 94% receive psychotherapy (of which 40% predominantly receive cognitive behavioural therapy) (Trimbos-instituut, 2012a).

Duration of treatment differs between health care providers. In primary care, GPs have on average two consultations with patients with mental health problems. In first-line mental health care, where treatment is predominantly provided by psychologists with additional training in health psychology, the mean duration of treatment is five months with an average number of seven consultations (Trimbos-instituut, 2012a). Finally, in second-line mental health care, treatment duration is three months or less for 42% of the patients, three months to one year for 32% of the patients and more than one year for 26% of the patients (Verbeek et al., 2011). Research by the Netherlands Institute of Mental Health and Addiction (Trimbos-instuut) showed that in primary care, treatment duration and prescription of medication among patients with mental disorders does not depend on problem severity. Contrary, within second-line mental health care, patients with higher problem severity receive more care and more often get medication (Trimbos-instituut, 2012b).

Figure 5.2. **The Netherlands is one of the least reliant countries on antidepressants**

Share of people in treatment[a] by nature of their treatment, 2005



Note: Europe is an unweighted average of 21 European countries.

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

Source: OECD calculations based on Eurobarometer 2005.

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Link between work and type of treatment

The type of treatment people receive is not only related to the severity of the mental disorder but also to socio-demographic and work-related factors. Results of the NEMESIS-2 study showed that people with moderate to severe complaints are more likely to receive treatment from second-line mental health care compared to people with no or mild complaints. Additionally, people who are living without a partner and who have no work are also more likely to receive second-line mental health care compared to people living with a partner and who have work. This relationship was irrespective of type of mental disorder and severity of complaints (Trimbos-instituut, 2012b).

The Dutch mental health care system and recent reforms

The adequacy of mental health care is influenced by the health care system in general. Several aspects matter, for instance, is mental health care insured, are GPs equipped to treat minor mental health problems and well instructed when to refer patients to first-line versus second-line mental health care and do health care specialists collaborate? Over the past few years, several changes have been implemented in the Netherlands to improve the health care system in general and the mental health care system specifically.

Significant reforms in the health insurance system

Before 2006, a public, compulsory health insurance was in place for low-income citizens with earnings below a set income level (EUR 33 000 per year in 2005). All citizens with earnings above this level were not allowed to join the public system and could choose to acquire private insurance (with higher premiums than the public insurance) or no insurance at all.

In 2006, the Health Insurance Act was implemented, replacing the old system.[3] Since then, all citizens are obliged to have basic health insurance, arranged through a private insurance company. Insurance companies are obliged to accept every citizen for basic health insurance, and each year, the government decides upon the type of health care covered by the basic insurance package. The premium for basic insurance can be decided by each insurance company but needs to be competitive as there are several insurers (e.g. 33 in 2014; Zorgkaart Nederland, 2014) from which people can choose (it is possible to choose a different insurer each year). Additionally, everyone can choose to extend the basic health insurance with additional health insurance packages as provided by the insurer (e.g. dental care) with an increase in the premium to be paid. Low income groups are supported through health care benefits, which can be requested if the yearly household income is below EUR 28 428 for a single person and below EUR 37 145 for couples (in 2014). The maximum compensation in 2014 was EUR 865 per year for singles and EUR 1 655 for couples, depending on the income level (the lower the income, the higher the compensation). As the average basic insurance package in 2014 costs around EUR 960 per year, this would mean a 90% compensation for single persons in the lowest income group.

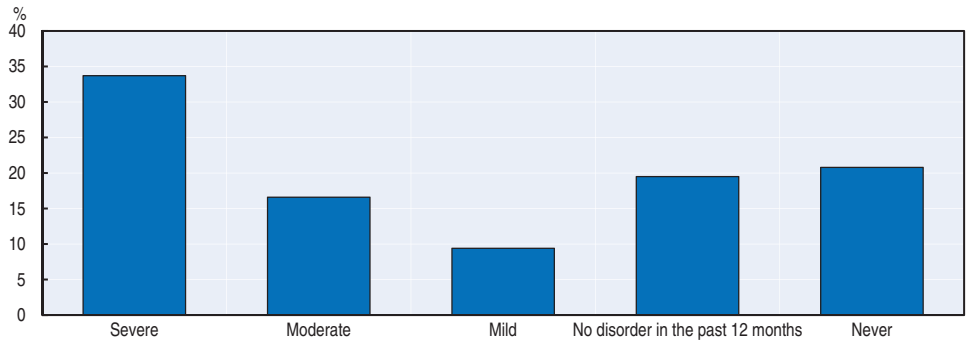
As the government can decide to change the health care covered in the basic insurance every year, the extent to which mental health care costs were insured differed over the past years. For example, in 2006 and 2007, costs for first-line mental health care were not insured at all. This changed in 2008, when the first eight sessions became compensated, but two years later, in 2010, the coverage was again reduced to five sessions. The coverage of first-line mental health care has not been changed until 2014, following new reforms as described below. Second-line mental health care became part of the basic insurance under the Health Insurance Act in 2008 (before that, it was covered by the Exceptional Medical Expenses Act – AWBZ).[4]

Reforms to improve first-line mental health care

Due to the substantial demands put on second-line mental health care, i.e. 815 778 unique patients compared to 91 500 in first-line mental health care in 2010 (Verbeek et al., 2011; GGZ, 2013a), and the acknowledgement of the importance of a good functioning mental health care system to reduce the societal burden of mental disorders, the government changed the system in 2014. The goal was to have more patients treated by the GP and in first-line mental health care, now called "generalised basic mental health care", to alleviate the caseload in second-line mental health care, now called "specialised mental health care". As shown in Figure 5.3, in 2009 a considerable share (40%) of the patients (aged 18-64 years) treated in mental health care have no, or no longer, symptoms that constitute a DSM-IV mental disorder (Trimbos-instituut, 2012b). To reduce the caseload, three changes have been put in place: i) more support for the GP to treat minor mental health problems; ii) a new referral model for the GP; and iii) a new treatment model for the generalised basic mental health care, including treatment of more severe cases (VWS, 2013).

Figure 5.3. **Nearly half of the people treated in mental health care have no mental disorder**

Disorder severity among adults, 18-64 years, who used mental health care in the past 12 months



Note: Data are based on a household survey conducted between 2007 and 2009 including 6 506 participants. This chart only includes the 431 participants who used mental health care in the past 12 months.

Source: M. ten Have, J. Nuyen, A. Beekman and R. de Graaf (2013), "Common Mental Disorder Severity and its Association with Treatment Contact and Treatment Intensity for Mental Health Problems", *Psychological Medicine*, No. 3, pp. 2203-2213, www.ncbi.nlm.nih.gov/pubmed/23388154 (accessed 15 September 2014).

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Extra support for GPs to provide mental health care

To better enable GPs to treat and refer patients with mental health problems, the possibility of using a mental health care specialist (called POH-GGZ, see Box 5.1. for more details) has been strengthened. As of 2014, more governmental resources have been made available for GPs to arrange a POH-GGZ in their practice, and the budget for the POH-GGZ can now be used more flexibly. More specifically, GPs can choose to hire other health care providers to organise and install a POH-GGZ in their practice. They can also invest the budget for optimising their screening methods for mental disorders, consulting psychologists/psychiatrists and offering patients e-mental health programs. From 2009 to 2011, the use of a POH-GGZ by GPs increased from 11% to 34% (Verbeek et al., 2011), and a survey conducted in 2013 among 820 GPs of the National Federation of General Practitioners showed that 62% of them worked together with a POH-GGZ (LHV, 2013). However, the rising demand for a POH-GGZ is becoming problematic due to an insufficient number of trained people. In April 2014, the National General Practitioners Association reported that 20% of the POH-GGZ vacancies were not being fulfilled.

Box 5.1. **The role of the POH-GGZ in GP's practice**

The function of the POH-GGZ (Dutch abbreviation for Practice Support Professional for Mental Health Care) was installed in the Netherlands in 2008 to support GPs in diagnosing, treating and referring patients with mental health problems. More specifically, the POH-GGZ's responsibilities for patients with minor mental health problems are: problem analysis/screening, developing and discussing the treatment plan, providing psycho-education, guiding/supporting self-management, as well as providing interventions aimed at behavioural change, indicated prevention, relapse prevention and increasing self-management of patients with chronic psychiatric conditions and potential comorbidity (Bakker and Jansen, 2013). The POH-GGZ is not authorised to prescribe medication. The professional background of the POH-GGZ is most often a psychiatric nurse (63%), psychologist (10%), social worker (7%) or general nurse (6%) (Verbeek et al., 2011*)*).

The connection with the GP's practice is guaranteed because the function of POH-GGZ falls under the GP's responsibility and is based on the following conditions: i) the POH-GGZ is the GP's liability and is part of the care a GP needs to offer; ii) the POH-GGZ closely collaborates with the GP; iii) the use of the POH-GGZ takes place on the GP's initiative; iv) the POH-GGZ reports to the GP and involves the GP directly in alarming situations; and v) when referral is needed, the GP needs to formally agree. Although not a formal obligation, there is a general consensus that the POH-GGZ should work in the GP's practice (VWS, 2013).

Referral model for GPs

On request of the Ministry of Health, a referral model for GPs has been developed to prevent too quick referral to specialised mental health care. The referral model is based on input from several experts in the field and provides guidelines for when treatment can take place by the GP (together with the POH-GGZ), in generalised basic mental health care or in specialised mental health care. The choice for referral needs to be based on five criteria: i) indication of a mental disorder according to the standards of the Diagnostic and Statistical Manual of Mental Disorders (DSM) (yes/no); ii) symptoms of mental health problems (subclinical, mild, moderate, severe); iii) risk level (low, moderate, high); iv) complexity (none, low, high); and v) course of complaints/disease. The criteria and the subcategories have been described in detail to assist GPs in deciding where a patients stands on each criterion (Bakker and Jansen, 2013).

Following the referral model, referral to specialised mental health care should take place when there is an indication of a mental disorder according to DSM standards and a high-risk level and/or high complexity. Treatment can take place by the GP and POH-GGZ when there is no indication of a mental disorder, or when there is an indication of a mental disorder but with subclinical or mild symptoms, a low-risk level, low complexity and a duration of complaints that does not yet fulfil the DSM guidelines of the specific disorder, or when there is a chronic problem which is stable and with a low-risk level. In all other cases, referral to generalised basic mental health care is deemed adequate (Bakker and Jansen, 2013).

Four care trajectories in generalised basic mental health care

As of 2014, four care trajectories can be offered in generalised basic mental health care, which are based on a patient's care need. The severity of the care need is assessed based on the five criteria used by GPs for referral (DSM disorder, symptom severity, risk level, complexity, course – see above). The four care trajectories of generalised mental health care are: short, medium, intensive and chronic (see also Box 5.2). The intensive trajectory allows for the treatment of more severe cases in generalised basic mental health care and should alleviate the treatment burden in specialised mental health care (VWS, 2013).

Box 5.2. **Decision guidelines for selecting a care trajectory in generalised basic mental health care**

Short. Symptoms are mild; although sufficient to speak of a mental disorder according to DSM standards, the impact of the symptoms on daily functioning is mild. Additionally, there is a low-risk level; there are no indications of potential (self-)neglect, suicide, violence or auto mutilation. There is only one single disorder or low complexity, meaning that comorbid disorders will not affect treatment of the primary disorder. Finally, regarding the course of the disorder, there are persistent complaints and previous interventions have not (completely) worked.

Medium. Symptom severity is moderate with an evident impact on daily functioning. The risk level is low to moderate; there are no indications of neglect, suicide, etc., or there might be a latent risk but the patient has sufficient protective factors such as adequate coping mechanisms or a good support system. There is only one single disorder or low complexity similar to the "short" trajectory. The duration of complaints is in line with the DSM guidelines related to the specific disorder.

Intensive. Symptom severity is high; most of the symptoms belonging to the disorder according to the DSM are present and have a substantial impact on daily functioning. As in the "medium" trajectory, the risk level is low to moderate and there is no to low complexity. The duration of complaints is in line with the DSM guidelines related to the specific disorder.

Chronic. This trajectory is for patients with stable or instable chronic mental problems or with severe mental problems but in remission. The risk level is low to moderate.

Each trajectory can be seen as an integrated care product, covering the total of activities and care provision (e.g. indicated or relapse prevention, e-mental health, consultations and treatment support by specialised mental health care) that can be offered (if needed, by various health care providers) to a certain group of patients who fit the patient profile (OECD, forthcoming). Treatment components are no longer separately paid for, but each trajectory has its own tariff. The Dutch Health Care Authority (NZa) decides on the maximum tariff for each of the four care trajectories, and health care insurers and health care providers can bargain over prices within these maximum boundaries (VWS, 2013). The government has provided an indication of which treatment components can be part of each trajectory with an estimation of the total treatment time (Bakker and Jansen, 2013). The new system of payment per trajectory instead of per individual treatment component is in line with the payment-for-performance system that was already installed in specialised mental health care since 2008 (see Box 5.3). It needs to be taken into account that this system has only just been introduced and that it remains to be seen whether and how it can work in practice. The coming years, the results of this reform will be monitored

by the government on several aspects, such as the referral behaviour of GPs, patients' treatment process, the development of the tariffs for the care trajectories and the declaration process by mental health care providers (VWS, 2013).

With the adaptations in the treatment system of generalised basic mental health care, the government has also changed the compensation in the basic insurance for mental health care. As before, specialised mental health care is still fully covered in the basic insurance, but since 2014 all care provided in generalised basic mental health care is also covered. The only prerequisite is that the patient has a referral from the GP or another medical specialist and is diagnosed with a mental disorder according to DSM standards.

Box 5.3. **The pay-for-performance system in specialised mental health care**

Since 2008, specialised mental health care is no longer financed per activity/treatment session, but financing is based on the total treatment path that has taken place, called the "Diagnosis Treatment Combination" (DBC). An explicit link is made between a patient's care need and the total treatment provided. A DBC describes the type of care (regular, emergency or chronic), the diagnosis (DSM-IV coding) and the treatment (inpatient or outpatient and nature of treatment) (OECD, forthcoming). This system of financing can also be called pay-for-performance, in which performance is referring to the total treatment provided (i.e. not about whether a health care provider performed well), and provides more room for demand-driven care and market forces. Moreover, it creates transparency about what kind of treatment path is used for patients with a different care need, and it can form a basis for entrepreneurship within specialised mental health care (DBC GGZ, 2006).

There are some DSM diagnoses that have been excluded by the government from the basic insurance to reduce overall health care costs, creating the risk that people will no longer look for treatment for these disorders. The exclusion of adjustment disorders is by far the most debated as this is a very common disorder within generalised mental health care; i.e. 24% of the patients were diagnosed with adjustment disorder in 2009 (Trimbos-instituut, 2012a). The government's reasoning is that an adjustment disorder is a mild disorder with a relatively short duration (VWS, 2011). However, research has shown that this disorder can have severe consequences. For example, a psychological autopsy study found that among 100 suicides, adjustment disorders were the most common diagnosed disorder (together with alcohol abuse) (Manoranjitham et al., 2010). Also, adjustment disorders have been found to be the most common diagnosis among self-harm patients presenting themselves at emergency departments (Taggart et al., 2006). Moreover, putting off treatment for a more mild disorder such as an adjustment disorder might, in the long run, increase

health care costs if it develops into a more serious mental disorder, such as a major depressive disorder, which will need longer treatment. Little research has been conducted to investigate this argument, but one study has shown that out of 100 patients interviewed five years after receiving the diagnosis of adjustment disorder, 32% (had) suffered from a more severe mental disorder (Andreasen and Hoenk, 1982).

When looking at work-related consequences, adjustment disorders are a frequent cause of sickness absence in the Netherlands (Koopmans et al., 2011). Although considered a mild disorder, adjustment disorders are related to a considerable amount of time off work; the average sickness absence episode due to an adjustment disorder is around 70 days (as comparison, the average sickness episode due to distress symptoms is 35 days and due to depression is around 170 days – based on Koopmans et al., 2011). Additionally, compared to depressive and anxiety disorders, adjustment disorders have the highest risk for recurrent sickness absence (Koopmans et al., 2011).

Implications and further reforms

Data up until 2011 show that the treatment gap in mental health care has been reduced due to the policy changes, but expenditures have also increased. This increase in expenditures has not been caused by higher prices but by higher usage of mental health care due to reduced stigma, reduced waiting times for accessing mental health care, a better focus on early identification of mental health problems in primary care and the introduction of regulated competition between mental health care providers resulting in the development of more effective, and more expensive, treatments for which demands increased (OECD, forthcoming).

Despite all policy changes, mental health care remains one of the most dispersed health care services in the Netherlands with four major schemes: i) the Health Insurance Act (Zvw), in which health insurers are key; ii) the Exceptional Medical Expenses Act (AWBZ), run by the federal government; iii) the Act for Social Support (WMO), organised by the local government (municipalities); and iv) direct funding from the Ministry of Security and Justice.

To improve transparency in the mental health care system, additional policy changes are planned for 2015. Especially, responsibilities/compensation for care of people with mental disorders will be clearly divided between the local government, the federal government and the health insurance scheme. The local government will be responsible for community care through the Social Support Act, which will be extended by transferring current community care responsibilities within the Exceptional Medical Expenses Act to the Social

Support Act. The federal government will remain responsible for in-patient long-term care through the new Act on Long-term Intensive Care (Wet LIZ), which will replace the current Exceptional Medical Expenses Act. Finally, through the Health Insurance Act, mental health care is covered with the compulsory health care insurance (Rijksoverheid, 2014).

Minimal focus on work in mental health care

Integrating mental health care and employment support is of paramount importance as research has shown that, on the one hand, work contributes to good mental health, and, on the other hand, good mental health improves employment outcomes (OECD, 2012). Promising results have been found by Lagerveld et al. (2012) regarding the return to work of people with common mental disorders who received a work-focused treatment by psychologists. Also studies by van der Klink et al. (2003), Blonk et al. (2006), and Schene et al. (2005) suggest that a focus on work during the treatment process facilitates return to work. Finally, a pilot project in the United Kingdom in which the Improving Access to Psychological Therapies (IAPT) initiative was complemented with employment services has shown to improve work outcomes (i.e. quicker return to work and increased likelihood of remaining in employment) (OECD, 2014).

Strong separation of mental health care and employment support

Mental health care and employment support (e.g. prevention of work disability, facilitating return to work) are separately dealt with in the Netherlands. This separation is mainly due to the fact that both systems are differently financed. Health care of workers with mental health problems is covered by personal health care insurance, while employment support of workers with mental health problems is the employer's financial responsibility, and those out of work fall under the government's responsibility.

The separation of mental health care and employment support poses problems, as there is a lack of collaboration between the care providers. Occupational physicians (OPs), hired by employers to provide employment support, understand how mental health problems impact work, but are not trained in the treatment of mental health problems. They can refer patients to mental health care, where the mental health problems are separately dealt with, while the OP focuses on employment support. Unfortunately, as discussed in chapter 3, there is limited communication between these health care providers, in part due to the medical secret which does not allow doctors to share patient information without their consent.

Additionally problematic is the fact that OPs are becoming less involved in employer's employment support activities as, since 2005, employers can choose to arrange these activities themselves. As a result, occupational health care knowledge in employment support is declining. Furthermore, the number of active OPs is reducing rapidly each year, with less and less medical students choosing to specialise as an OP (Capaciteitsorgaan, 2013). Overall, the integration of mental health care knowledge in employment support systems at the workplace is reducing.

Lack of initiatives by the mental health sector to offer employment support

As employment support and occupational health care are seen as the employer's and OP's responsibility, there is a lack of initiatives in mental health care to invest in improving work outcomes. For example, quality indicators for mental health care do not include work-related indicators (Zichtbare Zorg GGZ/VZ, 2013). Thus, there is also no integration of employment support/occupational health care knowledge in the mental health care system.

An exception to the lack of initiatives to integrate mental health and employment support is the treatment guideline on "Work and mental health complaints" for psychologists who are treating patients that are working or want to work. The goal of the guideline is to involve work and the work system in the treatment of patients with mental health problems (NIP/LVE, 2005). The guideline is derived from the earlier developed OP guideline on treating workers with mental health problems (see also Box 3.2., Chapter 3, for the OP guideline).

Research has shown that the "Work and mental health" guideline for psychologists is being used in practice. Out of 71 psychologists who were interviewed about the guideline, 32% responded that they were unfamiliar with the guideline, but about 58% of the interviewed said they had used it. The guideline was mainly used when psychologists recognised that the mental health problems were work-related and when problems were low in complexity. Finally, psychologists who were trained in the guideline (40%) more frequently used it (Oomens et al., 2009).

Comparable to other OECD countries, a better integration of mental health care and employment support has been established for severe mental disorders through the implementation of Flexible Assertive Communication Treatment (FACT) teams and Individual Placement and Support (IPS) programs. In the IPS model, specialised mental health care and IPS professionals closely collaborate in quickly finding paid work (following the "first place then train" ideology) and providing long-term support. IPS has

shown to be effective, compared to usual employment support, in improving work attainment in a Dutch study population with severe mental disorders (Michon et al., 2011). Currently, IPS is implemented by several centres for specialised mental health care as part of the ambulant team treating people with severe mental disorders (e.g. FACT teams), through collaboration with professionals from the public employment services (GGZ/UWV, 2012a). Nevertheless, research by Laitinen-Krispijn and Bijl (2002) shows that people on sickness absence for purely mental health problems are more likely to look for treatment in comparison with those with somatic health problems or a combination of both.

First steps taken to integrate mental health care and employment support

To improve care for people with mental health problems on public sickness and disability benefits, the Dutch Association of Mental Health and Addiction Care (GGZ) and the Employee Insurance Agency (UWV) signed a covenant in 2012 to increase collaboration (GGZ /UWV, 2012b). The covenant is specifically targeted at two groups: i) people with severe mental disorders which impede participation in work who have the capacity or will to work; and ii) young adults with mental health problems who have not been able to finish their study, adults with personality problems who can achieve stable functioning in the long run and adults with depressive/anxiety disorders or more milder disorders. A prerequisite is that these people receive public sickness or disability benefits and have a certain distance to the labour market. Non-sick unemployed are not included in the covenant, presumable because they are expected to be less distanced from the labour market.

GGZ and UWV have set two main goals in the covenant, which is only in its beginning phase. Firstly, they will guide the clients in the two target groups with a focus on optimal reintegration. Secondly, they will: i) focus on knowledge exchange about the function of work in the recovery process; ii) increase knowledge on mental disorders among UWV professionals; and iii) deliver personalised care. For the treatment of people with severe mental disorders, a work plan was already developed before the start of the covenant on how to increase collaboration between the two parties. For people with minor mental disorders, a research group has been installed to investigate what kind of collaboration is desirable. This group will also make an inventory of the collaborative activities that already take place between GGZ and UWV professionals. All activities related to the covenant will be discussed each year and provide input for new and follow-up activities for the coming year. Results of the covenant have not been presented yet.

Although the covenant between GGZ and UWV is a good first step for reaching sustainable collaboration between mental health care and employment support services, it still addresses only a relatively small part of the Dutch population with mental health problems. The agreement addresses the collaboration between

UWV and specialised mental health care, while a substantial part of unemployed people with minor mental health problems would be treated in generalised basic mental health care. Moreover, those who have a job do not fall under the covenant agreements, as they are not UWV clients. Possibly, this group will receive more attention in the future through the long-term strategy of GGZ in which keeping people at work or getting them into work is presented as one of the top priorities (GGZ, 2013b).

A potential fruitful endeavour for integrating mental health care and employment support could be the upcoming consultancy bureaus specialised in occupational health psychology. Consultants working for these bureaus are health psychologists, labour psychologists or clinical psychologists who are trained to provide mental health care to workers with mental health problems and have knowledge of and a strong focus on the work context (e.g. role of supervisor and colleagues, improving work functioning and sustainable return to work). These bureaus are primarily paid by the employer, which facilitates direct contact between the psychologists and the employer and the employer's OP; something that is lacking in other mental health care organisations.

Conclusions and recommendations

Many reforms have recently been introduced in the Netherlands to improve the mental health care system, in particular in primary care and generalised basic mental health care. First, more support is being provided to general practitioners to better identify mental disorders and treat patients with mild symptoms. Second, the new referral model stimulates referral of patients with mild-to-moderate mental disorders to generalised basic mental health care and should result in having only patients with severe mental disorders in specialised mental health care. Third, the referral model is in line with a stepped and matched care model in which patients receive the care they need from the most appropriate treatment provider depending on the severity of their complaints. Future evaluations will have to show whether the reforms are effective in reducing mental health care costs, absenteeism, presenteeism and disability benefit claims.

An important challenge for the Netherlands remains in integrating mental health care and employment support. Due to the strong separation of the two systems, mental health care providers are not required to focus on

work in the treatment process. Collaboration between mental health care providers and occupational physicians is limited. A good initiative to include a work focus in mental health treatment is the recently developed guideline for psychologists on treating workers with mental health problems.

A first step is being taken to improve collaboration between mental health care and employment support through the GGZ-UWV covenant. Until now, the covenant is only focused on people with mental disorders who receive public sickness or disability benefits and leaves out unemployed people with mild-to-moderate symptoms and employed people with mental health problems. Despite a well-developed occupational health system, also for employed people a proper co-ordination between mental health care and employment support services is lacking.

To conclude, when people with mental health problems enter the mental health care system, they will not receive employment support within this sector nor will they be connected to external employment support services. Concrete initiatives that integrate mental health care and employment support are lacking.

Improve access to care

- *Inform the public about mental health care coverage.* Due to frequent changes in the mental health care coverage in the basic health insurance, people may be unaware of whether and to what extent mental health care is insured. A lack of knowledge may cause people to refrain from treatment out of fear of high personal costs. It is important to educate the public that as from 2014 all mental health care is insured when referred by a GP/medical specialist, except of particular selected "mild" diagnoses.
- *Evaluate whether the own-risk clause causes social inequalities in access to care.* The own-risk clause of EUR 360 might create a barrier for people with low income to seek mental health care treatment, and, in this way, cause social inequalities in access to care.
- *Include mental health treatment for adjustment disorders in the basic health insurance.* Although milder than, for example, depressive or anxiety disorders, adjustment disorders can have severe health consequences when left untreated. Additionally, people with adjustment disorders often experience relatively long episodes of sickness absence and have a high risk for recurrent sickness absence. To ensure proper treatment, mental health care for adjustment disorders should also be reimbursed by the basic health insurance.

Stimulate a focus on employment support in mental health care

- *Train psychologists in the work-focused guideline.* The work-focused guideline for psychologists is a helpful tool to facilitate addressing work and the work context in the treatment of people with mental health problems. More training should be provided to psychologists working with clients who have work or would like to work to increase the use of the guideline. In line with suggestions by Oomens et al. (2009), the guideline could be made more concrete by providing examples from practice. Also, more information is needed on communication and co-ordination between involved parties (the occupational physician, employer and worker).

- *Include quality indicators on employment in mental health care.* Currently, quality indicators on the effectiveness of treatment on patient outcomes primarily focus on symptoms, functioning and quality of life and do not include a focus on work. As an example, in the United Kingdom two work-related quality indicators focus on the patient's employment status and sickness absence days. These indicators could also be registered within the Dutch mental health care system. Another work-related quality indicator that could be included is the assessment of a patient's work functioning. Ideally, these work-related quality indicators would be embedded in the purchasing system of health insurers (such that contracting mental health care providers is also based on results on work-related quality indicators).

- *Include employment outcomes in the generalised basic mental health care monitor.* Such quality indicators on employment outcomes could also be used in the monitor that is being developed to evaluate the reform of generalised basic mental health care. Currently, the goals of the monitor are described as, among others, evaluating the referral behaviour of GPs, the number of patients treated in each of the four trajectories and the costs of each trajectory. By including information on employment, sickness absence and work disability status in the monitor, more knowledge could be collected on how generalised basic mental health care can contribute to improving employment outcomes.

Develop initiatives to integrate mental health care and employment support

- *Incorporate workplace knowledge in GP practices.* GPs are the first contact for most people with mental health. Incorporating workplace knowledge in the GP practice would therefore be a key step in

integrating mental health care and employment support. For example, the POH-GGZ could be trained in the interactions between work and mental health and apply the psychologist's work-focused guideline (or an adapted version of the guideline targeted to the POH-GGZ). Another possibility to incorporate workplace knowledge in the GP practice could be the allocation of a government-funded budget for an employment specialist in a GP practice similar to the POH-GGZ.

- *Substantiate the covenant to actions enabling integrated care*. Although the covenant between GGZ and UWV was already established in April 2012, it is still in an exploratory phase, especially for people with mild-to-moderate mental disorders. Knowledge exchange and an inventory of already existing collaborations between the two parties are important, but more will be needed to realise integrated services at a national level. Concrete actions could be considered, such as conducting a pilot project on an Individual Placement and Support program adjusted to people with mild-to-moderate mental disorders as will be done soon in the United Kingdom (van Stolk et al., 2014).

Notes

1. In de Graaf et al. (2010), DSM-IV disorders were assessed with the Composite International Diagnostic Interview (CIDI) 3.0 and only include mood disorders, anxiety disorders, substance abuse disorders, attention deficit/hyperactivity disorder, conduct disorder and oppositional defiant disorder.
2. "Together Strong Against Stigma" contributed to the anti-stigma advertisement promoting a "help line" run by people with mental health problems for people who have a family member/friend/colleague with mental health problems where they answer questions about how can be dealt best with the situation. See also: www.sire.nl/campagnes/doorbreken-van-taboe-op-psychisch-ziek-zijn (accessed 15 September 2014).
3. More information on the Dutch health care system, and specifically the mental health care system, can be found in the recently published OECD Mental Health Analysis Profiles Netherlands report (2014).
4. The Exceptional Medical Expenses Act is a national insurance scheme providing reimbursement for long-term, in-patient and community care that is not covered by the private insurance.

References

Andreasen, N. and R. Hoenk (1982), "The Predictive Value of Adjustment Disorders: A Follow-up Study", *American Journal of Psychiatry*, Vol. 130, No. 5, pp. 584-590.

Bakker, P. and P. Jansen (2013), *Generalistische Basis GGZ, Verwijsmodel en productbeschrijvingen* [Generalised basic mental health care: Referral model and product descriptions], Bureau HHM, Enschede.

Blonk, R. et al. (2006), "Return to Work: A Comparison of Two Cognitive Behavioural Interventions in Cases of Work-related Psychological Complaints Among the Self-employed", *Work & Stress*, Vol. 20, No. 2, pp. 129-144.

Capaciteitsorgaan (2013), *Capaciteitsplan 2013 voor de medische, tandheelkundige, klinisch technologische, geestelijke gezonheid-, en aanverwante (vervolg) opleidingen* [Capacity plan 2013 for medical, dental, clinical technological, mental health and related (post) education], Capaciteitsorgaan, Utrecht.

DBC GGZ (2006), De productstructuur DBC GGZ [Product structure of the Diagnosis Treatment Combination within mental health care], Diagnose Behandel Combinatie Geestelijke Gezondheidszorg, Utrecht.

de Graaf, R., M. ten Have and S. van Dorsselaer (2010), "De psychische gezondheid van de Nederlandse bevolking, NEMESIS-2: Opzet en eerste resultaten" [The mental health of the Dutch population, NEMESIS-2: Design and first results], Trimbos-instituut, Utrecht.

GGZ Nederland (2013a), "GGZ in de Zorgverzekeringswet, tabellen over de jaren 2008-2010" [Mental health care in the Act on health care insurance, tables over the period 2008-2010], Geestelijke Gezondheidszorg Nederland, Amersfoort.

GGZ Nederland (2013b), "Meerjarenvisie GGZ Nederland 2013-2020. De ggz in beweging" [Long-term vision GGZ Nederland 2013-2020. Mental health care on the move], Geestelijke Gezondheidszorg Nederland, Amersfoort.

GGZ/UWV (2012a), *Bijlage 1 behorend bij het convenant tussen Geestelijke Gezondheidszorg Nederland en Uitvoeringsinstituut Werknemers Verzekeringen, Werkplan 2012* [Attachment 1 belonging to the covenant between The Dutch Association of Mental Health and Addiction Care and the Employee Insurance Agency, Work plan 2012], Geestelijke Gezondheidszorg Nederland/Uitvoeringsinstituut Werknemers Verzekeringen, Amsterdam.

GGZ/UWV (2012b), *Convenant tussen Geestelijke Gezondheidszorg Nederland en Uitvoeringsinstituut Werknemers Verzekeringen* [Covenant between The Dutch Association of Mental Health and Addiction Care and the Employee Insurance Agency], Geestelijke Gezondheidszorg Nederland/Uitvoeringsinstituut Werknemers Verzekeringen, Amsterdam.

Kolenberg, A. (2012), *Stigma en werk in beeld, Rapportage vooronderzoek* [Stigma and work in focus], Stichting Samen Sterk tegen Stigma.

Koopmans, B., and P. Verhaak (2012), *Verwacht zorggebruik als gevolg van de eigen bijdrage in de tweedelijns GGZ* [Expected health care use as a consequence of the premium for specialised mental health care], Nederlands instituut voor onderzoek van de gezondheidszorg, Utrecht.

Koopmans, P. et al. (2011), "Recurrence of Sickness Absence Due to Common Mental Disorders", *International Archives of Occupational and Environmental Health*, Vol. 84, No. 2, pp. 193-201.

Lagerveld, S. et al. (2012), "Work-focused Treatment of Common Mental Disorders and Return to Work: A Comparative Outcome Study", *Journal of Occupational Health Psychology*, Vol. 17, No. 2, pp. 220-234.

Laitinen-Krispijn, S. and R. Bijl (2002), *Werk, psyche en ziekteverzuim: Aard en omvang van psychische stoornissen, ziekteverzuim en zorggebruik in de beroepsbevolking* [Work, psyche and sickness absence: Type and scale of mental disorders, sickness absence and health care use in the working population], Trimbos-instituut, Utrecht.

LHV (2013), "Praktijkondersteuner GGZ steeds vaker in dienst van huisarts" [Supporting counsellor mental health care increasingly hired by the general practitioner], website Landelijk Huisartsen Vereniging, http://lhv.artsennet.nl/Actueel/Nieuws6/Nieuwsartikel/Praktijkondersteuner-ggz-steeds-vaker-in-dienst-van-huisarts.htm (accessed 28 February 2014).

Manoranjitham, A. et al. (2010), "Risk Factors for Suicide in Rural South India", *British Journal of Psychiatry*, Vol. 196, pp. 26-30.

Michon, H. et al. (2011), *Effectiviteit van Individuele Plaatsing en Steun in Nederland, Verslag van een gerandomiseerde gecontroleerde effectstudie, Deelrapport 1: Bevindingen na 18 maanden follow-up* [Effectiveness of Individual Placement and Support in the Netherlands, Report of a randomised controlled trial, Report 1: Results after 18 month follow-up], Rob Giel Onderzoekscentrum, Groningen, and Trimbos-instituut, Utrecht.

NIP/LVE (2005), *Werk en psychische klachten, Toelichting op de richtlijn voor psychologen* [Work and mental health complaints, Explanation of the guideline for psychologists], Nederlands Instituut van Psychologen/Landelijke Vereniging van Eerstelijnspsychologen, Amsterdam.

OECD (forthcoming), "Mental Health Analysis Profile (MHaP): Netherlands", *OECD Health Working Paper*, OECD Publishing, Paris.

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

OECD (2012), *Sick on the Job? Myths and Realities about Mental Health and Work*, OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264124523-en.

Oomens, P., J. Huijs and R. Blonk (2009), "Effectiviteit van de richtlijn 'Werk en psychische klachten' voor psychologen" [Effectiveness of the guideline on 'Work and mental health complaints' for psychologists], TNO, Hoofddorp.

Overweg, K. and H. Michon (2011), *Factsheet Panel Psychisch Gezien*, Trimbos-instituut, Utrecht.

Rijksoverheid (2014), "Veranderingen in de AWBZ" [Changes in the AWBZ], www.rijksoverheid.nl/onderwerpen/algemene-wet-bijzondere-ziektekosten-awbz/veranderingen-in-de-awbz (accessed 15 September 2014).

Schene, A. et al. (2005), "Psychische aandoeningen en arbeid: een vergelijking van interventies" [Mental disorders and work: a comparison of interventions], *Psychopraxis*, Vol. 7, No. 3, pp. 110-115.

Taggart, C. et al. (2006), "Accuracy of diagnosis at routine psychiatric assessment in patients presenting to an accident and emergency department", *General Hospital Psychiatry*, Vol. 28, No. 4, pp. 330-335.

ten Have, M., J. Nuyen, A. Beekman and R. de Graaf (2013), "Common mental disorder severity and its association with treatment contact and treatment intensity for mental health problems", *Psychological Medicine*, Vol. 43, No. 10, pp. 2203-2213, www.ncbi.nlm.nih.gov/pubmed/23388154 (accessed 15 September 2014).

ten Have, M., S. van Dorsselaer and R. de Graaf (2012), *Tijd tussen ontstaan van een psychische aandoening en eerste zorgcontact, Resultaten van de 'Netherlands Mental Health Survey and Incidence Study-2' (NEMESIS-2)* [Time between occurrence of a mental disorder and first health care contact: Results of the 'Netherlands Mental Health Survey and Incidence Study-2' (NEMESIS-2)], Trimbos-instituut, Utrecht.

Trimbos-instituut (2012a), *Trendrapportage GGZ 2012 Deel 2A: Toegang en zorggebruik, GGZ in de eerste lijn, De rol van de huisarts en de eerstelijnspsycholoog* [Trend analysis on mental health care 2012 Part 2A: Access and health care use, primary mental health care, The role of the general practitioner and the first-line psychologist], Trimbos-instituut, Utrecht.

Trimbos-instituut (2012b), *Trendrapportage GGZ 2012 Deel 2B: Ernst van de psychische aandoening als voorspeller van de aard en intensiteit van zorggebruik, Resultaten van de 'Netherlands Mental Health Survey and Incidence Study-2' (NEMESIS-2)* [Trend analysis on mental health care 2012 Part 2B: Severity of the mental disorder as predictor of the type and intensity of health care use, Results of the 'Netherlands Mental Health Survey and Incidence Study-2' (NEMESIS-2)], Trimbos-instituut, Utrecht.

van Stolk C., J. Hofman, M. Hafner, B. Janta (2014), *Psychological Wellbeing and Work: Improving Service Provision and Outcomes*, RAND Europe, Cambridge.

van der Klink, J. et al. (2003), "Reducing Long Term Sickness Absence by an Activating Intervention in Adjustment Disorders: A Cluster Randomised Controlled Trial", *Occupational and Environmental Medicine*, Vol. 60, pp. 429-437.

Verbeek, M., A, Knispel and J. Nuijen (2011), "GGZ in tabellen" [Mental health care shown in tables], Trimbos-instituut, Utrecht.

VWS (2013), "Voorhangbrief POH-GGZ en Generalistische Basis GGZ" [Prelimary letter on POH-GGZ and Generalist Basic mental health care], Ministerie van Volksgezondheid, Welzijn en Sport, Den Haag.

VWS (2011), "Beantwoording schriftelijke vragen Ontwerp Besluit Zorgverzekering en curatieve GGZ" [Answering of written questions: Design of Decree on Health care insurance and curative mental health care], Ministerie van Volksgezondheid, Welzijn en Sport, Den Haag.

Zichtbare Zorg GGZ/VZ (2013), *Kernset prestatie-indicatoren 2013 Geestelijke Gezondheidszorg & Verslavingszorg* [Core set of performance indicators for mental health and addiction care in 2013], Zichtbare Zorg GGZ/VZ, Den Haag.

Zorgkaart Nederland (2014), website, www.zorgkaartnederland.nl/zorgverzekeraar (accessed 28 March 2014).

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