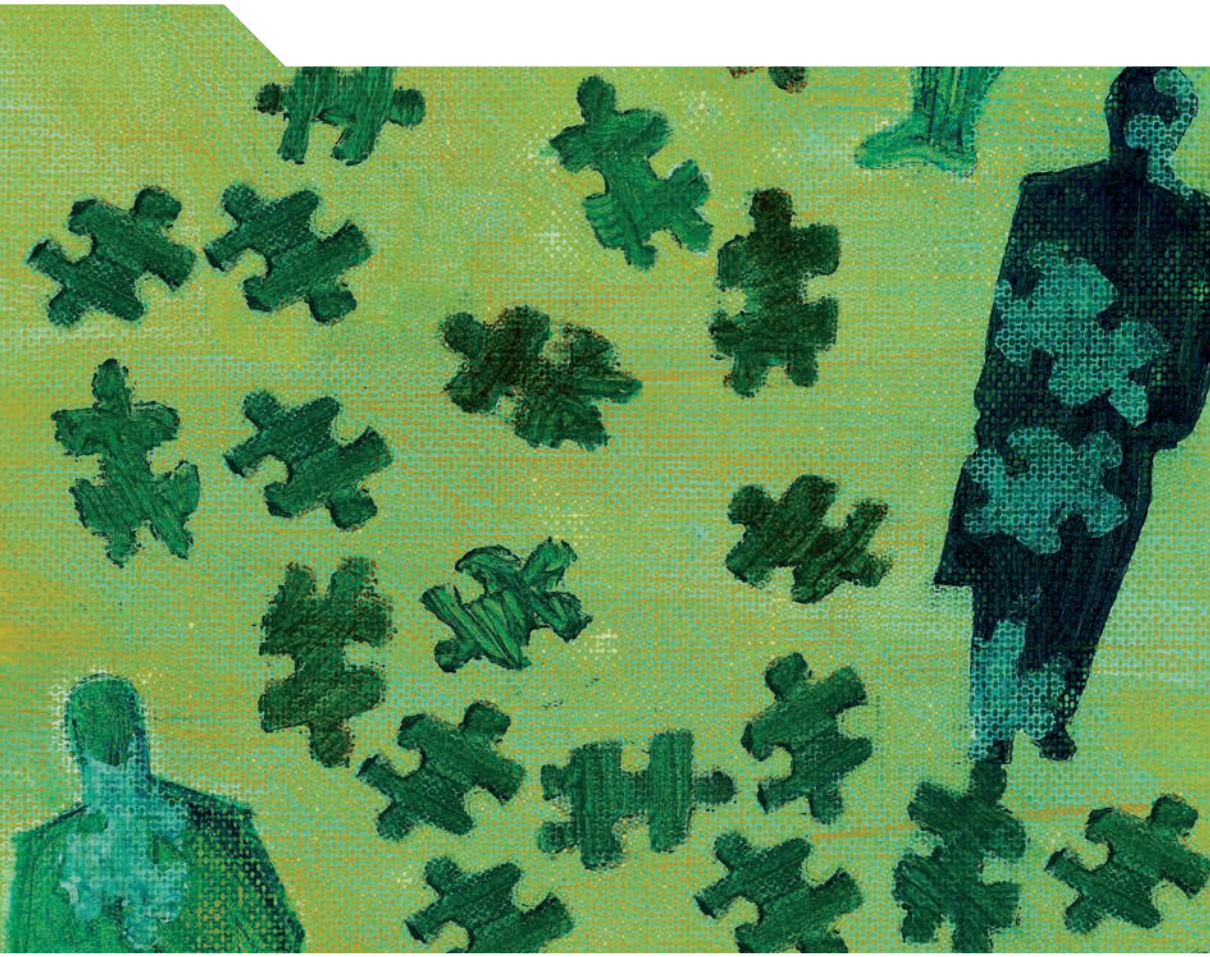
Mental Health and Work

NORWAY



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Mental Health and Work: Norway

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BETTER POLICIES FOR BETTER LIVES

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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; helping those employed but struggling in their jobs; avoiding long-term sickness and disability caused by a mental disorder; and involving treating physicians more in job retention and rehabilitation.

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 Norway 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 effectiveness of sickness and disability benefits and vocational rehabilitation, the capacity of the health care system, and the transition from school to work. The other reports look at the situation in Australia, Austria, Belgium, Denmark, the Netherlands, 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 of Norway 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 country mission was undertaken by Shruti Singh from the OECD and Niklas Baer from the Psychiatric Services of Baselland (Switzerland). The report was prepared by Niklas Baer under the supervision of Christopher Prinz. Statistical work was provided by Dana Blumin. Valuable comments were provided by John Martin and Mark Keese. The report also includes comments received from various Norwegian ministries and authorities. Special thanks go to Arne Kolstad and Bjørn Halvorsen from the Ministry of Labour who accompanied the OECD team during the country mission and supported the development of the report.

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Acronyms and abbreviations

ADHD	Attention-Deficit and Hyperactivity Disorder
GP	General Practitioners
HIS	Health Interview Survey
IAPT	Improving Access to Psychological Therapies (IAPT)
ICD	International Classification of Diseases
IWA	Inclusive Workplace Agreement
NAV	Norwegian Labour and Welfare Administration
NEET	Neither Employed nor in Education
NHS	National Health Survey
NIS	Norwegian Social Insurance Scheme
NOK	Norwegian Krone
PPS	Educational and Psychological Counselling Services
WAA	Work Assessment Allowance

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. This also applies in Norway which has the highest sickness absence incidence and disability benefit caseload in the OECD despite a traditionally strong work-first approach. In view of Norway's economic performance as well as the high level of spending on health care and education, mental health-related inequalities seem very high. Norwegian policy makers recognise the need for action to prevent people from dropping out of the labour market with a mental illness and help those with a mental disorder in finding jobs. Accordingly, Norway has established a broad range of policies and reforms to tackle the exclusion of people with mental ill-health. These include a national strategy on work and mental health, developed jointly by the Ministry of Health and the Ministry of Labour; and the integration of the public employment service, the social insurance and parts of the municipal social assistance into a Labour and Welfare Administration (NAV), thus offering a strong structure for early intervention and co-ordinated support.

Despite sound policies and support services, however, fundamental change is needed in order to improve the situation for the people concerned. Change will need to include the recognition that the perspective of an easy access to sickness absence and permanent disability benefit play to the characteristics of most people with mental health problems, namely fears and avoidant behaviour. Further changes should include improving the cooperation between mental health care and NAV services; supporting employers at an early stage of a mental health-related workplace problem; and tackling the high rate of dropout from upper secondary education due to mental health problems.

The OECD recommends to Norway to:

- Take action to avoid sickness absence of workers with mental health problems as much as possible and instead solve the problems at the workplace.

- Expand the Employment Support Centres of NAV to fill the wide gap between general prevention and rehabilitation by introducing and expanding early intervention measures.
- Stop the fragmentation of services in mental health care and rehabilitation and the disconnection between treating physicians and NAV by developing integrated support models.
- Minimise school dropout and improve the transition to employment by defining clear responsibilities for on-going individual follow-up for students at risk.

Assessment and recommendations

Norway combines a unique mix of a favourable economic and labour force situation and very high investments in education and health with a pervasive exclusion of people with health problems from the labour market. While the Norwegian system has generated a high and stable employment rate over the last decades, one-fifth of the population receives income supports due to health problems, and spending on disability and sickness benefits amounts to around 5% of GDP, by far the highest level in the OECD. The causes for this combination cannot be found either in a lack of vocational rehabilitation policies or a lack of elaborated support structures; both are well developed. Rather, the reasons lie in a political reluctance to revise a very generous social protection system; to implement effectively far-reaching changes introduced in the past decade; and to enforce new obligations rigorously.

Blocking the exclusion perspective

For many people with a mental disorder, the welfare-driven strategy has the contrary effect of exclusion and inequality: people with a severe mental disorder have a nine-fold unemployment rate compared with the national average and, more generally, Norwegians with a mental disorder did not benefit from the favourable labour market situation in the period leading up to the recent crisis, as reflected in falling employment and rising unemployment rates for this group. Relatively easy access to long-term or permanent work incapacity benefits not only plays to some typical characteristics of mental illness like, for instance, fear avoidance, withdrawal and passivity, but also isolates people with mental disorders from the world of work.

To improve labour market access and job retention of people with a mental disorder, perspectives should be changed. Employees with a mental health problem are more frequently taking long-term sick leave compared with people with a physical health problem, and their sickness rates have steadily increased, despite an elaborate system of sickness absence monitoring. Similarly, the drop-out rate of clients with a mental disorder

from vocational rehabilitation programmes is high despite a strong work-first approach and a broad range of supports over several years. Finally, disability benefit claims are seldom rejected and, once awarded, rarely reassessed, although beneficiaries with a more moderate mental disorder typically have a fluctuating work capacity. To improve the effectiveness of existing measures, the perspective of long-term sick leave and permanent disability benefit should in many cases be blocked from the beginning.

Matching responsibilities and funding structures

Responsibility for sickness and disability benefits is very unequally distributed, with the bulk of the costs covered by social insurance. Employers have a key role in preventing sick leave and supporting the return-to-work process, but are financially involved in short-term absences only, reducing their efforts to avoid harmful long-term sick leave. Employees also face limited incentives to avoid sickness absence, receiving compensation equal to 100% of their previous wage for up to one year. Co-workers represented by their unions, and the physicians' certification behaviour also influence workplace dynamics and return-to-work, but unions and doctors do not bear any of the financial costs of their decisions. Finally, the municipalities – responsible for health, education and rehabilitation services – have much impact on the rates of exclusion, but are not involved in health-related work incapacity funding either. Although it is difficult to quantify the responsibility of each actor, new ways of co-financing should be discussed to improve their commitment to labour market inclusion of people with mental ill-health.

Reconsidering sickness absence policies

Norway has, by far, the highest rate of sickness absence in the OECD. Despite a recent focus on partial sickness leave, full-time sick leave is still the rule. General practitioners (GPs) are responsible for sickness certification, but they find it difficult to assess the duration, degree and future development of functional capacity. Sickness absence regulations are quite elaborate but there is no early identification of sick leaves due to mental illness. Medical and vocational professionals come in too late in the process, if at all, and the elaboration of a return-to-work plan is left to the employer and the employee. Managers and human resource professionals are not trained sufficiently to identify and intervene in mental health problems. The strong focus of existing services such as occupational health services or the labour inspection authority on sickness prevention and health promotion, results in a lack of targeted early intervention and support to employers.

Revising disability assessment procedures and eligibility criteria

The eligibility criteria for a disability benefit are strict in Norway requiring a permanent loss of work capacity and excluding social problems or milder mental disorders. Nevertheless, common mental disorders like mood and neurotic disorders are the main reason for a disability benefit in people with mental health problems, especially in older age. The strict eligibility rules do not always seem to be followed. Moreover, around one-third of the new beneficiaries have never sought treatment for their mental health problem. The possibility to receive a disability benefit after several years of vocational rehabilitation undermines the seriousness of the integration efforts. Another potential problem lies in the disability assessment process itself, which is influenced significantly by the claimants; often takes place without the involvement of a mental health specialist; and lacks a focus on periodic reassessment.

Improving the outcomes of vocational rehabilitation

The many different vocational rehabilitation services in Norway support an increasing number of clients. However, education and training are still the most frequently used measures despite a modest effectiveness, and they are used mostly as re-education measures for persons with higher education rather than to up-skill people with low education. Conversely, wage subsidies to employers, which are rather effective, are hardly used. Finally, the large group of people at risk of dropping out of the labour market but still at work is not reached by vocational rehabilitation. The existing employer support centres could offer a basis for support to employees struggling in work provided these centres would be expanded; turned into multidisciplinary services; and given responsibility for individual follow-up.

Strengthening health care integration

The disintegration of mental health care and employment services, as well as the fragmentation within the mental health system itself with municipal primary care and regional specialist care, is a main barrier for labour market inclusion. The pioneering Norwegian strategy for work and mental health has tried to build a bridge between the Labour and Welfare Administration (NAV) and the health care sector. In order to yield sustainable improvements, however, structural measures are needed. For instance, the few insurance physicians in the NAV offices are not allowed to see the claimants; when in treatment, the significance of the patient's employment situation is undervalued; and many people on sick leave have an undetected mental disorder indicating a need for improved co-operation between general and specialist care. A more integrated approach is also hindered by a lack of inter-sectoral routine data. Finally, while people with a

severe mental disorder and more generally all those who can afford private psychotherapy seem to have good access to mental health services, the majority of people with moderate disorders and working problems have long waiting times for psychiatric treatment.

Due to the early onset of most psychiatric disorders and the importance of a good education for future performance in the labour market, mental health problems in pupils should be tackled in concerted action. This would be important because non-completion of upper secondary education is common in Norway, especially in apprenticeships. There are a number of obstacles: pedagogical and psychological services are not obliged to co-operate with health services; general health services often do not refer young patients to specialists; and teachers do not receive enough support. In case of inward-oriented mental disorders not associated with difficult behaviours or emotions, the chance to get specialist treatment is low. Finally, there are no services and no integrated concepts to systematically secure a successful and sustainable transition to work.

Summary of the main OECD recommendations for Norway

Key policy challenges	Policy recommendations
1. There is a lack of incentives to avoid sick leave or to support early return-to-work	• Increase the duration of the sickness payment obligation for employers, or introduce co-financing for the entire sick-leave period. • Reduce the replacement rate in case of sickness absence from 100% to around 80%. • Discuss a co-financing of health-related work incapacity costs by unions and municipalities.
2. Employers are not equipped to deal with mental health problems in the workplace	• Develop criteria for rapid intervention by NAV and the treating physician in case of mental health-related work problems or sick leave. • Expand resources and responsibilities of the Employer Support Centres to secure earlier intervention, support for employers and follow-up of employees in need of help. • Develop integrated processes for employers, NAV professionals and physicians to co-operate in case of employees' non-compliance.
3. GPs feel uncertain in assessing sickness absence duration and work capacity	• Assure as little and short sick leave as possible for common mental disorders. • Train physicians in dealing with workplace problems of patients, and strengthen sanctions for systematically non-compliant physicians. • Base long-term sickness certifications on an interdisciplinary assessment which involves a specialist and a NAV professional.
4. Strict disability benefit eligibility is not applied in practice	• Expand explicit social and medical exclusion criteria for a disability benefit. • Request an adequate specialist treatment before awarding a disability benefit on the grounds of a mental disorder. • Strengthen the requirements on compliance with rehabilitative measures and apply them rigorously in practice. • Base disability benefit awards on an interdisciplinary assessment rather than merely the existing medical record.
5. There is no outflow from disability benefits into employment	• Introduce periodic reassessments of disability benefit entitlements. • Provide better incentives for municipalities and enterprises to offer jobs for disability beneficiaries and provide long-term follow-up to employers and beneficiaries.

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

Key policy challenges	Policy recommendations
6. Vocational rehabilitation measures are not as effective as possible	• Provide more workplace-oriented job retention services targeting employers and employees. • Decrease the share of education and training measures for people with mental disorders in favour of the provision of wage subsidies. • Provide education measures above all to people with low education (up-skilling). • Define rehabilitative programme packages for relevant target groups.
7. Mental health care and employment support are not integrated	• Develop collaboration between NAV, local GPs and District Psychiatric Centres. • Install NAV professionals in the District Psychiatric Centres. • Partly integrate GPs into the NAV offices.
8. The mental health sector has no systematic focus on employment	• Establish work-related issues as a core competence in the District Psychiatric Centres. • Implement employment as a main outcome in mental health care and develop work-related health care quality indicators. • Develop an employment and workplace-related mental health training curriculum for GPs. • Develop a screening tool for doctors to detect mental health problems in general practice.
9. High rates of school dropout and increasing disability benefit rates among young adults	• Increase the resources of school-based health services and ensure an integrated approach with the Pedagogical and Psychological Services. • Establish a close contact between vocational education, NAV professionals and municipal health services. • Expand the Qualification Programme explicitly to youth with mental health problems and secure identification and treatment.

Chapter 1

Mental health and work challenges in Norway

This chapter refers to the key findings of the recently published OECD report Sick on the Job? *and summarises the characteristics of people with mental health problems which contribute to the special challenges in job retention and labour market re-integration for this group. The high mental health-related employment inequalities in Norway are discussed and compared with those in other countries. The chapter also provides a description of some organisational characteristics of the systems involved.*

Introduction: definitions and objectives

The OECD report *Sick on the Job? Myths and Realities about Mental and Work* concluded that a three-fold shift in policy is required to respond effectively to the challenges of ensuring greater labour market inclusion of people with mental illness (OECD, 2012). More attention needs to be given to *i)* mild and moderate mental disorders as opposed to severe disorders; *ii)* disorders concerning the employed and unemployed; *iii)* early intervention instead of rehabilitation of people with mental disorders ; and *iv)* systematically integrating health care with support systems in education and social insurance.

Understanding the characteristics of mental ill-health is critical for devising the right policies. The key attributes of a mental disorder are above all an early age at onset. The median age of onset of mental disorders is around 14 years. This implies *i)* most people struggling at work have been vulnerable long before they get contacted by support systems; *ii)* many of the later beneficiaries already had problems at school and during the transition to the labour market; and *iii)* many of them have not had a stable work biography. The early onset hits children and adolescents in the middle of the development of their personality often resulting in "difficult" and uncertain personalities.

Further key attributes of mental disorders are its severity; 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 the person's work capacity. However, contrary to physical problems milder and even sub-clinical forms of mental health conditions can be disabling if they persist over a longer period. The diagnosis also matters, *e.g.* schizophrenia and personality disorders have a relatively bad employment prognosis. At the same time, mental illness of any type can be severe and persistent. The majority of mental disorders fall in the category mild or moderate, often including affective and neurotic disorders. The symptoms of these disorders are mostly well treatable, but there remain two barriers, which are not solved so far: *i)* professional treatment can remedy the symptoms of the illness, but it cannot "cure" a vulnerable personality; and *ii)* often treatment is not sought, or treatment is not effective with respect to work outcomes.

One important general challenge for policymakers is the very high rate of non-awareness, non-disclosure and non-identification of mental disorders – which is directly linked with the stigma attached to mental illness. The early onset, its potential consequences for failures in education and work, and its impact on the early building of an often uncertain

personality, combined with the fears and prejudices of the environment, reduce the chances of disclosure and treatment seeking – which would be the usual behaviour in people with physical problems.

The OECD report *Sick on the Job? Myths and Realities about Mental and Work* identified two main directions for reform. First, more emphasis needs to be given to (early) identifying of problems and needs; and intervening at key stages of the lifecycle, including during the transition from school to work, at the workplace, and when people are about to lose their job or to move into the benefit system. Secondly, a coherent approach across government services needs to be taken which integrates health, employment and, where necessary, other social services.

Mental disorder in this report is defined as mental illness reaching the clinical threshold of a diagnosis according to psychiatric classification systems such as the International Classification of Disease (ICD-10) which is in use since the mid-1990s (ICD-11 is currently in preparation). Based on this definition, at any moment some 20% of the working-age population in the average OECD country is suffering from a mental disorder, with lifetime prevalence reaching 40-50% (Box 1.1).

The purpose of this report is to examine how policies and institutions in Norway are addressing the challenge of ensuring that mental ill-health does not mean exclusion from employment and that work itself contributes to better mental health. A number of specific issues are addressed. How are the critical institutions and stakeholders – schools, employers, employment services and psychiatric services – organised and resourced to identify people with a mental disorder? What is done and how quickly when a problem has been identified, and what is done more generally without stigmatising those in need? How are the different actors in Norway co-operating and how are different services integrated to ensure people get the right services quickly to access the labour market, remain in their job or return to employment?

The structure of the report is as follows. This first chapter sets the scene by looking at key social and labour market outcomes for people with a mental disorder, in Norway compared with other countries, and describing the organisational characteristics of the main systems catering for people with mental illness. This is followed by chapters which look consecutively at the policy challenges Norway is facing in a number of key areas: the sickness benefit scheme; the disability benefit scheme; the vocational rehabilitation scheme; the mental health system; and the education system. Each chapter concludes with specific policy recommendations.

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, and hence the existence of a mental disorder can be identified. This is also the case in Norway. However, administrative data do not include detailed information on an individual's social and economic status and they cover only a fraction of all people with a mental disorder.

On the contrary, 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 review 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 www.oecd.org/els/disability and OECD (2012a) for a more detailed description and justification of this approach and its possible implications. Importantly the aim here is to measure and compare the social and labour market outcomes of people with a mental disorder, not the prevalence of mental disorders as such.

For this report, data from the *Norwegian Level of Living and Health Survey* for 1998 and 2008 are used to estimate labour market outcomes of the target population. The mental disorder variable in this survey is based on the HSCL-25 Hopkins Symptom Checklist, a validated self-rating scale with 25 questions on the presence and intensity of anxiety and depression symptoms over the previous week.

High mental health-related social inequalities in Norway

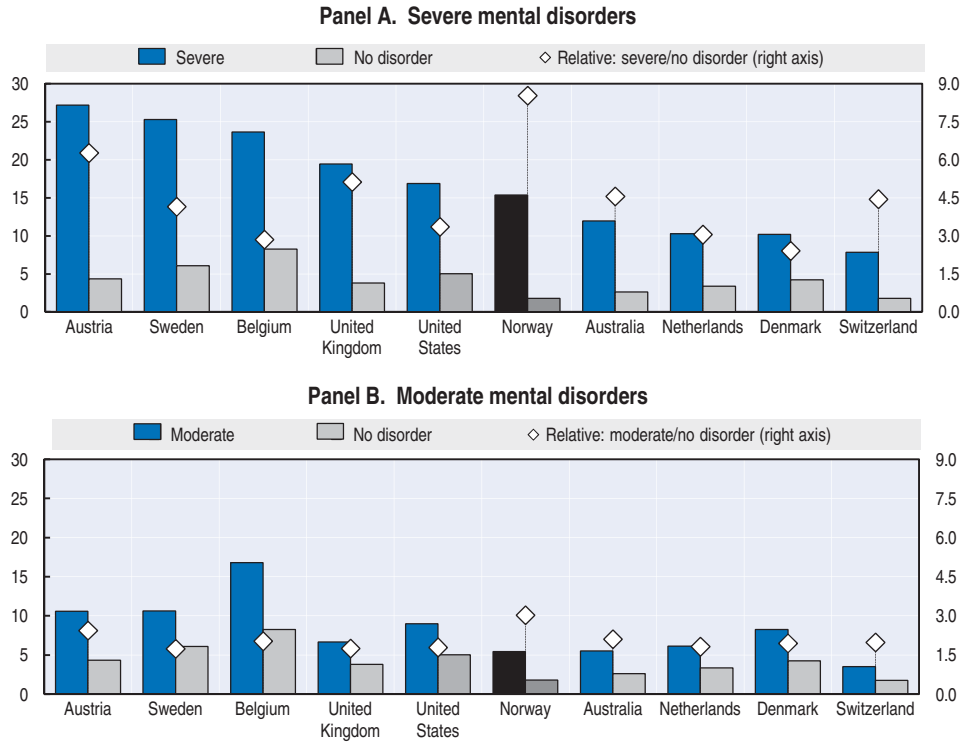
Norway has a high overall standard of living and generous benefits for disadvantaged people, but also a relatively equal distribution of opportunities in the population as regards income, housing and access to services. Numerous regulations and measures have been created to guarantee equal rights and possibilities for vulnerable groups. In view of this, resulting inequalities depending on mental health status are rather large.

Mental health-related employment differences are large

Although Norway has very high rates of employment for people without a mental disorder (around 85%), the employment rate for people with a severe mental disorder, at 55%, is lower than in comparable or neighbouring countries such as Switzerland (65%) and Denmark (60%). Many people with mental health problems cannot participate in the healthy Norwegian labour market. The participation gap between healthy individuals and people with mental health problems is even larger in terms of unemployment (Figure 1.1).

Figure 1.1. **Norway has the highest mental health-related unemployment gap**

Unemployment rates by mental-health status (percentages; left axis) and relative unemployment ratios (people with mental disorders over those without such a disorder; right axis) in the late 2000s



Source: OECD calculations based on national health surveys (NHS) or interview (HIS) surveys. Australia: NHS 2007/08; Austria: HIS 2006/07; Belgium: HIS 2008; Denmark: NHIS 2005; Netherlands: POLS Health Survey 2007/09; Norway: Level of Living and Health Survey 2008; Sweden: Survey on Living Conditions 2009/10; Switzerland: Health Survey 2007; United Kingdom: Adult Psychiatric Morbidity Survey 2007; United States: NHIS 2008.

People with a severe mental disorder have a nine-fold unemployment rate (Figure 1.1, Panel A), and those with a moderate mental disorder a three-fold rate (Panel B), compared with people without a mental health problem. It is not the level of unemployment (15% for severe and 5% for moderate mental disorders) which is striking but the strong unemployment gap with healthy people. Selection effects alone cannot explain this difference, as the much lower gap in Switzerland – which has a comparably low level of unemployment – shows.

Substantial and increasing mental health-related income gaps

The employment disadvantages for individuals with mental health problems also result in relatively low income levels (OECD, 2012). At below 80% of the average income, the income gap with respect to the incomes of healthy people is larger than in other countries such as Austria, Belgium, Denmark, Sweden and Switzerland. This suggests that people with a mental disorder who are employed stay on a relatively low income level.

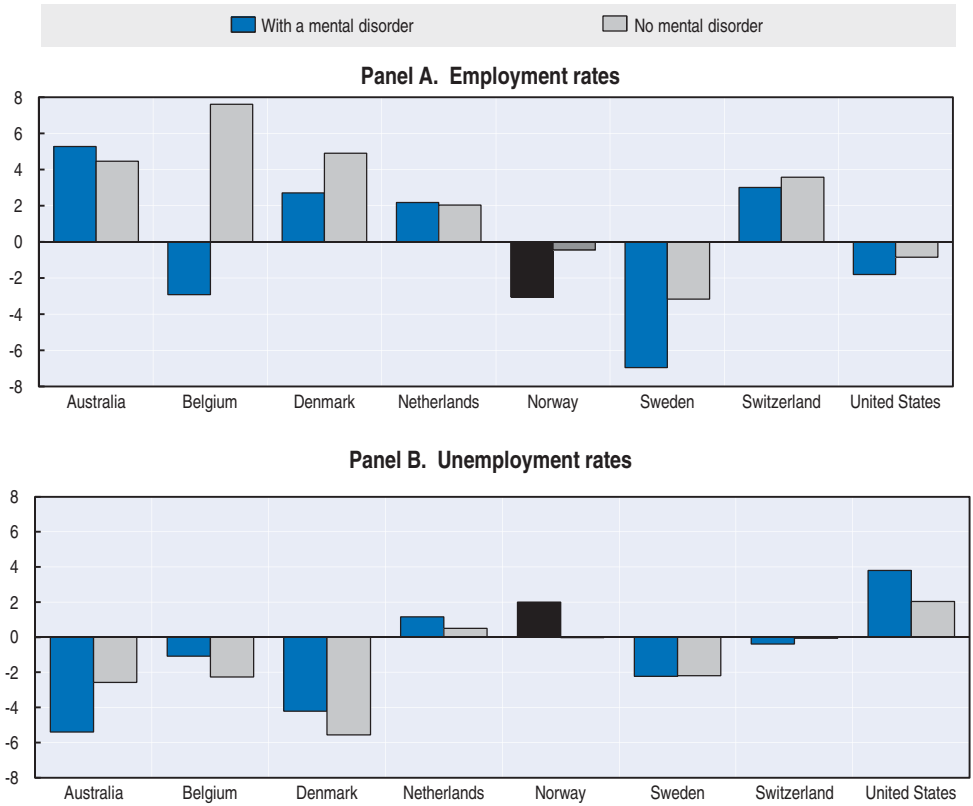
Moreover, people with severe mental disorders in particular have not profited from a substantial decline in poverty rates in Norway since 1998. While the percentage of individuals without a mental disorder living below the poverty threshold halved between 1998 and 2008, the share of people with a severe mental disorder living with a household income below 60% of the median remained at the same elevated level.

Norwegians with mental illness have not profited from economic growth

People with mental health problems have not profited from economic growth and an expanding labour market in Norway. Both the employment and the unemployment gap have widened between the mid-1990s and mid-to-late 2000s despite a positive economic climate in these years (Figure 1.2, Panel A). The employment rate for individuals with mental disorders has fallen by three percentage points over this period, and the unemployment rate increased by three percentage points (Panel B). Moreover, there is some evidence that skilled workers who immigrated to Norway in large numbers in 2006-09 have displaced Norwegian low-wage earners – including many workers with mental health problems often working in unskilled positions (Jean and Jimenez, 2007; Bratsberg and Raaum, 2012; Bratsberg *et al.*, 2012).

Figure 1.2. **In Norway, employment rates of people with a mental disorder declined during the period of strong growth up to the recent crisis**

Percentage-point change in employment and unemployment rates for people with and without a mental disorder between the mid-1990s and the mid- to late-2000s



Source: OECD calculations based on national health surveys (NHS) or interview (HIS) surveys. Australia: NHS 2001 and 2007/08; Austria: HIS 2006/07; Belgium: HIS 1997 and 2008; Denmark: NHIS 1994 and 2005; Netherlands: POLS Health Survey 20001/03 and 2007/09; Norway: Level of Living and Health Survey 1998 and 2008; Sweden: Survey on Living Conditions 1994/95 and 2009/10; Switzerland: Health Survey 2002 and 2007; United Kingdom: Adult Psychiatric Morbidity Survey 2007; United States: NHIS 1997 and 2008.

Mental illness is highly prevalent in unemployed and inactive persons

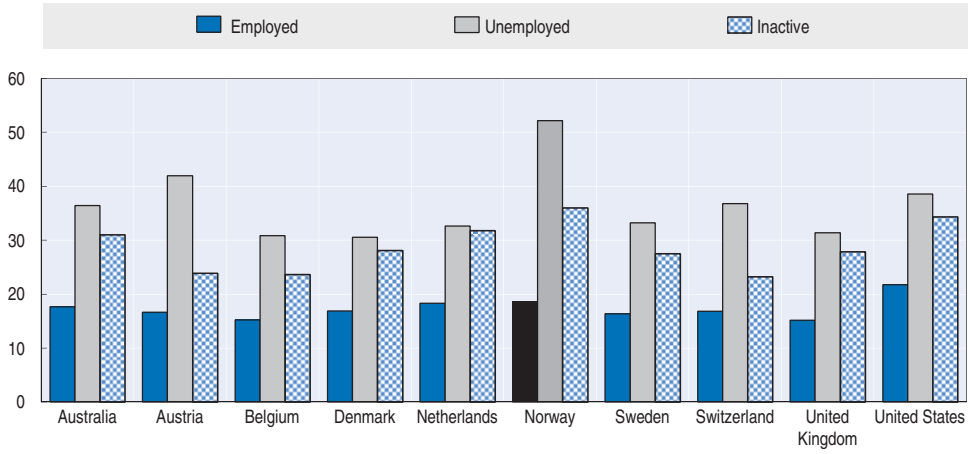
Although unemployment is a relatively rare phenomenon in Norway compared with other countries, the share of unemployed persons suffering from a mental disorder is striking. More than every second unemployed Norwegian has a severe or moderate mental disorder; by far the highest number in a sample of OECD countries and much higher than in other countries with a low unemployment rate (Figure 1.3). Norway also has the

highest share of mental disorders among the inactive population (over one-third).

This finding raises some questions. It is unclear in which direction the causality goes, *i.e.* whether labour market exclusion causes or worsens mental health problems or whether pre-existing mental disorders cause unemployment and inactivity. Evidence from research suggests that both directions work in parallel. The two explanations have somewhat different policy implications. If the high disorder prevalence was caused by exclusion, to increase inclusion should receive even higher priority in Norway. In this case, strategies should target on incentives for people with mental health problems to leave benefits as early as possible. If the inverse were true (mental health problems cause exclusion of the labour market), the question arises why the numbers of people with mental health problems leaving the labour market have increased. In this case, policy would have to develop interventions to mitigate the negative effects of mental disorders on work ability, and increase incentives for employers to retain workers with mental health problems.

Figure 1.3. **Mental disorders are particularly frequent among the unemployed**

Prevalence of severe or moderate mental disorder (in percentage), by labour force status, latest year available



Source: OECD calculations based on national health surveys (NHS) or interview (HIS) surveys. Australia: NHS 2007/08; Austria: HIS 2006/07; Belgium: HIS 2008; Denmark: NHIS 2005; Netherlands: POLS Health Survey 2007/09; Norway: Level of Living and Health Survey 2008; Sweden: Survey on Living Conditions 2009/10; Switzerland: Health Survey 2007; United Kingdom: Adult Psychiatric Morbidity Survey 2007; United States: NHIS 2008.

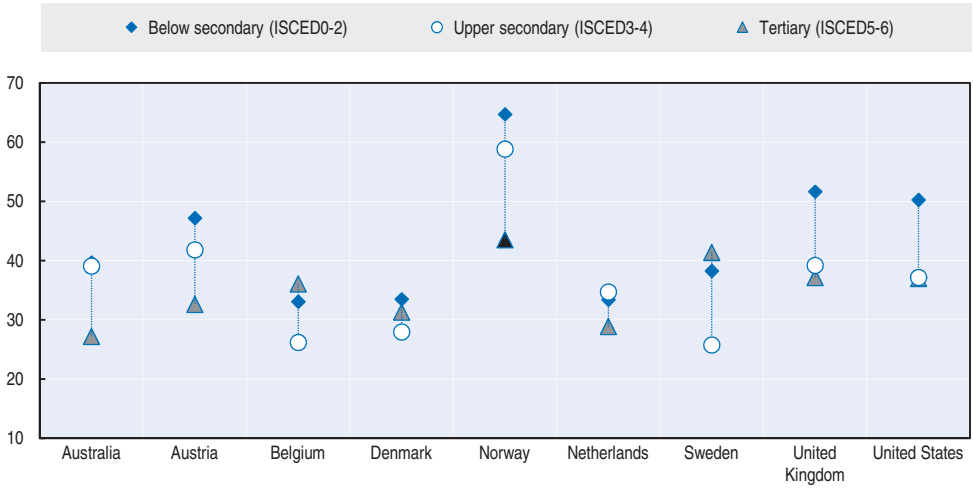
Most likely the effects go in both directions, with a selective group of people with a more severe mental disorder drifting into unemployment and disability. The very high rate of mental health problems among the unemployed in Norway suggests that the unemployed are a highly vulnerable group. But the majority of the large group of people, who are inactive for health reasons, most of them with only a moderate mental disability (severe disability is a relatively rare phenomenon), seem to develop a mental health condition or see a worsening of their condition due to their withdrawal from the labour market.

Most unemployed with low education have mental disorders

Not only are income and labour force status, in comparison with other countries, especially unequally distributed in Norway when it comes to mental health, but mental health depends also largely on educational achievement (Figure 1.4). Lower educational attainment goes hand-in-hand with a poorer mental health status, with almost two-thirds of unemployed people with low educational attainment suffering from a mental disorder.

Figure 1.4. **The risk of poor mental health varies by education**

Prevalence of mental disorders among unemployed (in %), by level of education, latest year



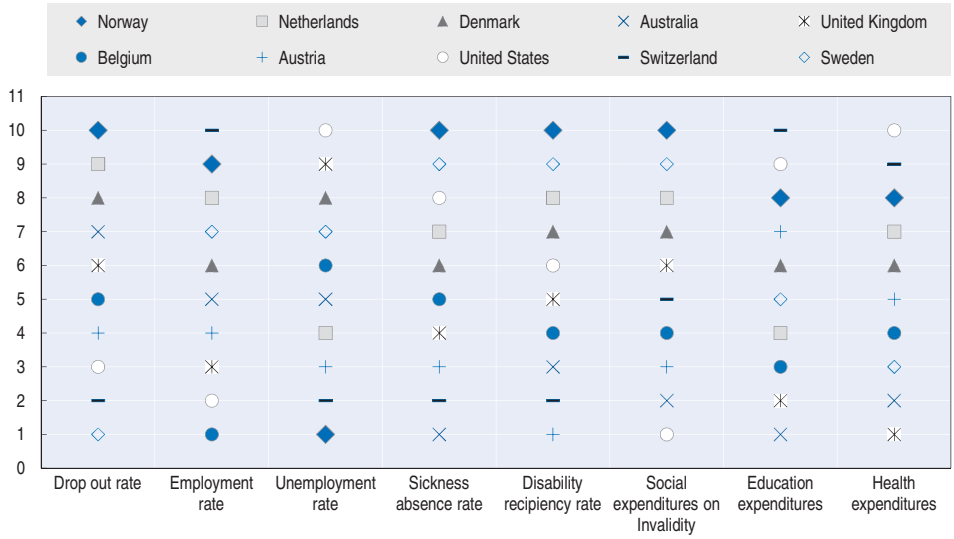
Source: OECD calculations based on national health surveys (NHS) or interview (HIS) surveys. Australia: NHS 2007/08; Austria: HIS 2006/07; Belgium: HIS 2008; Denmark: NHIS 2005; Netherlands: POLS Health Survey 2007/09; Norway: Level of Living and Health Survey 2008; Sweden: Survey on Living Conditions 2009/10; Switzerland: Health Survey 2007; United Kingdom: Health Survey of England, 2006; United States: NHIS 2008.

Conclusion on key outcomes in Norway

Norway is in many respects a country of the extremes. No other OECD country combines to such a high degree a high living standard (GDP per capita), and high investments in education and health with a pervasive exclusion of people with health problems from the labour market (Figure 1.5). On the one hand, Norway has the second highest employment rate (75.3% in 2011), the lowest unemployment rate in the OECD area (3.3% in 2011) with a low share of persons being long-term unemployed (around 11.6% in 2011), and a healthy economic situation with a high and growing GDP per head. Furthermore, the income distribution is relatively equal and poverty rates are low.

Figure 1.5. **Norway ranks first in several key policy parameters**

Ranking (1 to 10) of selected countries in a range of policy parameters, latest year available[a]



a. Social expenditures, 2007; education expenditures, 2008; dropout and disability recipiency rate, 2009, health expenditures and sickness absence, 2010 and 2011 otherwise.

Source: OECD Education Database, OECD Labour Force Statistics, OECD Social Expenditure Database, OECD Health Expenditure and Financing Dataset and OECD Disability Database.

On the other hand, a large group of people is excluded from the labour market, or threatened by exclusion. Norway has a very high disability benefit caseload, with high inflows and a very low rate of outflows, resulting in high social expenditures. Sickness absence incidence is the highest among OECD countries. Public and mandatory private expenditures on disability

and sickness benefits amount to around 5% of GDP, by far the highest level in the OECD. In addition, many people receive social assistance. In total, almost one-fifth of the population receive income supports due to health problems or disability; nearly everybody who is not working (Duell *et al.*, 2009). Finally, Norway ranks third in the OECD in terms of the costs of the health care system as well as the education system (in both cases after Switzerland and the United States).

The unique combination of healthy general conditions and large benefit dependency rates has remained quite stable over the past decades, despite different waves of reforms and the provision of an elaborate system of vocational measures. Some barriers reflect the specific consequences of the very generous benefit system. This system prevents poverty of ill persons, but it is also a trap, supporting exclusion and the worsening of peoples' health conditions and quality of life. The Norwegian welfare model provides universal financial protection for both the unemployed and those with a disability, but at the expense of employment for people with (mental) health problems.

There is also another striking combination in Norway of a generous compensation policy for people out of work and a strong vocational integration focus (OECD, 2010a). Norway has one of the most generous benefit systems in the OECD area, with universal population coverage and high financial replacement levels over a long duration or, in the case of sickness and disability, even permanently. However, Norway has also the strongest integration approach, with a range of vocational rehabilitation supports which can be applied at any time and over several years. This finding suggests that the reasons for the exceedingly high labour force exclusion due to health problems in Norway are not simply caused by a lack of support structures or a lack in integration policies in any of the systems involved. Possibly, the problems are more related to the ways, in which all these integration policies and measures have been regulated, implemented, monitored and evaluated.

Organisational characteristics of the systems involved

The relationship between mental health problems and work functioning is complex and, therefore, concerns a variety of different political areas. In addition, every system is organised across different policy layers, with organisations and specific responsibilities on state, county and municipal level. This section briefly describes the characteristics of the involved political and administrative systems relevant in the context of this report: social protection, education, mental health care and the labour market.

Centralised policies and autonomous municipalities

The state is responsible for policy initiatives, performance control and co-ordination in the area of labour market, social insurance, welfare, and health care policies. National directorates are responsible for policy implementation and professional advice to the municipal authorities. The responsibility for the provision of primary education, primary health care, long-term care and social services lies with the 430 municipalities. In between the state and municipal level, 19 counties are responsible for secondary education, and four regional health authorities for specialised health services.

Although most services are nationally financed and organised, most health, education and social services are provided by the municipalities. The autonomy of the municipalities has a long tradition in Norwegian politics, and it has been reinforced by recent reforms. However, many municipalities are small, with around 50% having less than 5 000 inhabitants, resulting in difficulties to provide the whole range of services in small communities. Moreover, the autonomy of the municipalities may run counter to the targets of the ministries, *e.g.* resulting in the protection of traditional and locally rooted but relatively ineffective rehabilitative services such as sheltered workshops, instead of implementing more workplace-oriented supported employment services.

The Ministry of Labour promotes an active labour market policy

The Ministry of Labour is responsible for an active labour market policy to fight exclusion from employment. Norway has traditionally been formulating an active and rehabilitation-oriented approach, by providing a large range of vocational rehabilitation measures in order to get unemployed persons back to work. With respect to the labour market, there is a tradition of tripartite agreements concluded by the social partners and the government.

Preventive focus of the Norwegian Labour Inspection Authority

The Labour Inspectorate (attached to the ministry) with more than 500 employees oversees that enterprises follow the requirements of the Working Environment Act, including procedures to enable employees on sick leave to return to work. The Inspectorate is responsible for 250 000 enterprises and carries out around 20 000 inspections every year. Recent activities include campaigns related to requirements regarding the sick-leave procedures as well as activities with sectors where workplace conflicts and mental strain are highly prevalent. The possible sanctions for employers in the case of non-fulfilment of the requirements of the Working Environment Act are quite strict in theory, while there are no sanctions for employees.

Health promotion by the Occupational Health Services

Enterprises in branches with a higher risk of work-related injuries, illnesses and strain are obliged to have an Occupational Health Service, regardless of the number of persons they employ. There are around 500 occupational health service units in Norway, covering 20 000 enterprises and almost half of the total workforce. A typical unit consists of a physician, a nurse, an ergonomist and a safety engineer, with limited psychological expertise. The costs of having an occupational health service are covered by the employer. The main focus of occupational health services is prevention and, according to the regulations, services should not be involved in resolving health problems that are not related to the work environment, which is the responsibility of the GP (Lie, 2009). Although such a clear distinction is often not possible in practice, this regulation excludes most mental disorders from support.

Concentrated services by the Labour and Welfare Administration

The Labour and Welfare Administration (NAV) has since 2006 full responsibility for the implementation of labour market policies, the provision of employment and vocational rehabilitation services and early intervention in prolonged sickness absences. NAV is the result of a far-reaching merger of the different employment-related support systems in Norway, namely the Public Employment Service, the National Insurance Service and the Social Assistance Service, in order to ensure more co-ordinated and effective benefits, services and administration. To achieve this, on a municipal level employment and welfare services were concentrated in shared offices. NAV employs around 16 000 professionals in 460 local offices, with a budget of more than NOK 300 billion (corresponding to 30% of the Norwegian state budget.

Obligation for close co-ordination between local and state services

The third element of NAV, social assistance, is still under the authority of the municipalities, which are obliged to work in close partnership with NAV. However, there are still two chains of command, limiting the impact of national policies in practice. Funding of the benefits and services of NAV and social assistance is also still different; the former being financed by the state and the latter by the municipalities. The 2010 law on social services ensures that local services are co-ordinated with employment services provided by the state agency. The NAV reform has great potential, but so far has paid no attention to mental health care and challenges.

Mental health care is organised on three layers

The organisation of the mental health care system in Norway is based on three layers: primary mental health care is provided by the municipalities, specialised mental health care is under the responsibility of the counties, and the highly specialised hospitals are supervised by the state. An important national organisation is the Directorate of Health, a professional body with three roles as: a health care advisory body to different target groups (*e.g.* by monitoring trends in health care services); an authority implementing policies (*e.g.* action plans, campaigns or giving grants); and an administrator of regulations within the field of health care. Together with the Directorate for Labour and Welfare, the Health Directorate has a main responsibility for the implementation and evaluation of the measures of the national strategy on mental health and work.

District psychiatric centres as drivers for decentralisation

In Norway, the process of deinstitutionalisation of mental health care started late compared with other countries. The expansion of community mental health care, organised on the district level (therefore, district psychiatric centres) and staffed with specialists (psychiatrists, psychologists and psychiatric nurses), has been the core of the mental health care reform starting in 1999. The district centres provide specialised services in local environments, and co-operate with hospitals and primary care providers in the municipalities. However, with a responsibility for a population of around 50 000, the catchment area of these centres is rather small (due to the low population density in most Norwegian areas) – limiting the potential for specialised services.

The centres provide ambulatory services, day care, short-term inpatient care, long-term treatment and rehabilitation, consultation, support for primary care professionals and crisis intervention. It is important that the district psychiatric centres are perceived as competent partners by GPs, but this has not always been the case. When asked whether they have a good impression of psychiatric services, around 45% of GPs disagreed (Bjertnaes *et al.*, 2008).

Private psychiatrists and psychologists for adult and child psychiatry

Private psychiatrists and psychologists, for adults as well as for children, also provide specialised services. Norway has around 0.2 psychiatrists per 1 000 inhabitants, the second highest number after Switzerland. Nevertheless, there is a substantial waiting period for persons who do not have a serious mental disorder. Only for people who pay treatment fully out-of-pocket are there no waiting lists. Otherwise, the waiting period is usually

between a few weeks and several months. Since the implementation of the Escalation Plan, the number of psychologists in the municipalities has increased strongly, and today around 3% of the adult population and 4.5% of children and adolescents are in specialised treatment. Thus, the capacity of specialised mental health care has improved over the past 10 years but waiting times are still too long.

Upper secondary education is a separate layer

Compulsory education starts at the age of six and comprises seven years of primary and three years of lower secondary education. The responsibility for the provision of the first ten grades lies with the municipalities, although there is a state curriculum. Afterwards, normally at the age of 16, Norwegian youth have the right to move to upper secondary education, which lasts for three years. This can be general education or vocational training. Upper secondary education is the responsibility of the 19 counties. Almost all children begin upper secondary education (97% in 2009) but, at around 30%, the rate of adolescents who do not complete upper secondary within five years after entry is relatively high (OECD, 2010b). Only 40% complete vocational courses in the stipulated time.

Lack of co-operation between school services and mental health care

Teachers and students can use a range of municipal or county-based services in the case of mental health problems. Over 150 educational and psychological counselling services (PPS) with 2 000 professionals of which roughly 200 psychologists provide a network across the country. The PPS will refer the student to a specialist health service (via the GP) and give guidance to the school on how to handle students with socio-emotional problems. In the case of behavioural or drug problems, teachers can contact child welfare which is part of the local social service. Students with problems may also contact the school advisor who will guide or refer them to specialists. Finally, there are school health services which are part of the municipal health services and not necessarily located at the school. Problems arise because none of these services assumes responsibility for the student and because of the lack of co-operation between mental health services and the PPS.

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Chapter 2

Reconsidering Norwegian sickness absence policies

This chapter provides an in-depth discussion of the development of sick leave against the background of the high level of long-term sickness absence which is the main route to disability benefit in Norway. The chapter discusses the increasing share of long-term sick leave due to milder mental disorders; the role of physicians certifying sick leave; and existing and possible new funding mechanisms for the costs of sickness absences. Finally, eligibility criteria for sick leave due to mental health problems and the use of partial sickness absence are questioned.

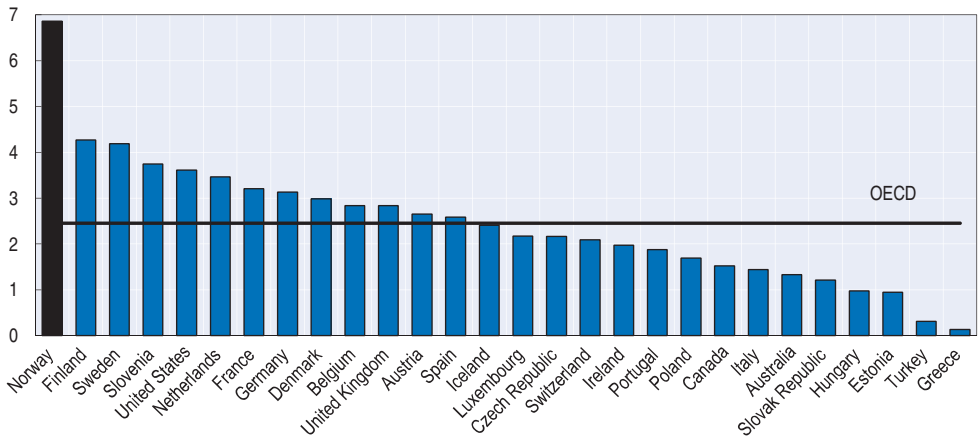
The trap of high and prolonged sickness absence

Sickness absence is a major public health problem

The very high sickness absence incidence rate in Norway is a major public health problem (Figure 2.1). Norway has by far the highest rate of work absences of full-time employees in the whole OECD area, with almost 7% of the workforce being on sick leave at any moment. This is almost twice the rate of other Nordic countries, which also have high absence rates relative to other countries.

Figure 2.1. **Norway has the highest sickness absence rate by far**

Incidence of sickness absence of full-time employees in selected OECD countries, 2010[a,b]



a. 2004 for Australia, 2007 for Iceland, 2008 for the United States and 2009 for Ireland. The incidence of work absence due to sickness is defined as the share of full-time 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.

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

Source: *OECD Absence Database*, based on the European Union labour force survey and national labour force surveys for Australia, Canada and the United States.

The annual number of persons on sick leave was nearly 530 000 in 2009 (340 000 in 1994), reporting around 650 000 sickness spells (400 000 in 1994), which is an increase of 59% in sick persons and 63% in sickness spells since 1994 – much more than the rise of the employed population in this period. There are important systemic differences between Norway and other countries with respect to the regulations on sick leave, other benefits

and dismissals, which contribute to but cannot fully explain the very high absence incidence (see Box 2.1 for the main characteristics of the sickness benefit scheme).

Box 2.1. **Characteristics of the Norwegian sickness benefit scheme**

All injured persons are entitled to daily cash benefits in the case of work incapacity due to sickness. The benefit is paid from the first day of absence for a period of 260 working days (*i.e.* 52 weeks) at a level of 100% of the last wage. In the first 16 days, the employer is responsible for the payment, thereafter the National Insurance Scheme.

Based on both the Working Environment Act and the National Insurance Act, different meetings must be held between the employer, the employee, the NAV officer and possibly, the treating physician, in order to shorten the absence duration. If such meetings are not held, there may be sanctions. Generally, GPs are supposed to motivate their patients to continue working if possible and to consider whether partial sick leave would be an option.

The employer must initiate a follow-up plan in co-operation with the employee before the end of the 4th week of sick leave, setting out what steps are needed for an employee to be able to continue to work, at least on a partial basis. The plan includes: *i)* an evaluation of the employees' tasks and work ability; *ii)* relevant adjustments from the employer; *iii)* the need for external assistance; and *iv)* a follow-up plan. This plan must be sent to the treating physician. The only exceptions to this rule are if it is clear that the employee will return to work without any adjustments, or that the employee will be unable to return to work.

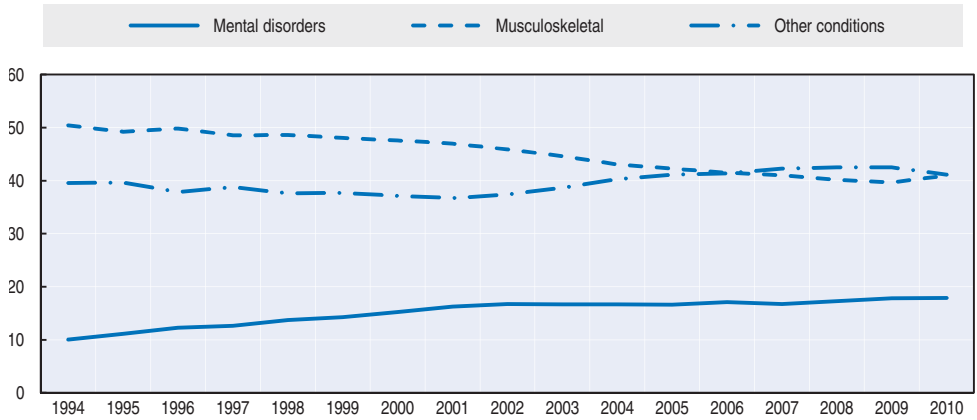
After seven weeks of sick leave, the employer must hold a meeting with the employee to update the follow-up plan. If necessary, the certifying doctor must be present. Within nine weeks the employer must send the updated plan to NAV. Within eight weeks the treating doctor has to report extended sick leave, and must document the medical reasons why work is not possible. The NAV office must organise a second meeting within the first 26 weeks of sick leave. This meeting is mandatory for all the actors.

Increasing share of sick-listed employees due to mental health problems

During the same period, the health conditions composition of absentees has changed (Figure 2.2). The share of persons who are sick because of mental illness rose by eight percentage points, from 10% to 18% between 1994 and 2010, while the share of musculoskeletal disorders fell from 50% to 41% in the same period, with all other medical conditions remaining stable. The number of sick persons with mental disorders rose by a factor of 2.6 from 34 000 to 88 000 in 2010, and the number of persons with musculoskeletal disorders increased by a factor of 1.2 from 170 000 to 203 000.

Figure 2.2. **An increasing share of sick leave is caused by mental illness**

Share of sick persons by health condition, 1994-2010



Source: OECD questionnaire on mental health.

A recent analysis of changes in mental health-related sickness absences in Norway from 2000 to 2011 shows that it is above all the milder mental health conditions which have increased (Brage *et al.*, 2012). While sick leave due to anxiety and depression decreased from 8.9 to 6.1 episodes per 1 000 employees, the rate for "psychological distress" as a reason for sickness absence more than doubled from 4.6 to 9.7 episodes. Moreover, the mean sick leave duration of these milder mental health reasons increased from 40 days in 2000 to 46 days in 2011. Finally, in these milder conditions the rate of partial sick leave was only 24% in 2011. The increase of psychological distress as a reason for sick leave applies to all gender and age groups. It is unclear whether this development is caused by a diagnostic shift by certifying physicians; however, it is possible that changes of the classification system and better training of the physicians have led to a more restricted use of the depression diagnosis. Nevertheless, the strong increase of sickness absence due to unspecified psychological distress, which does not reach the criteria for a mental disorder diagnosis, remains striking.

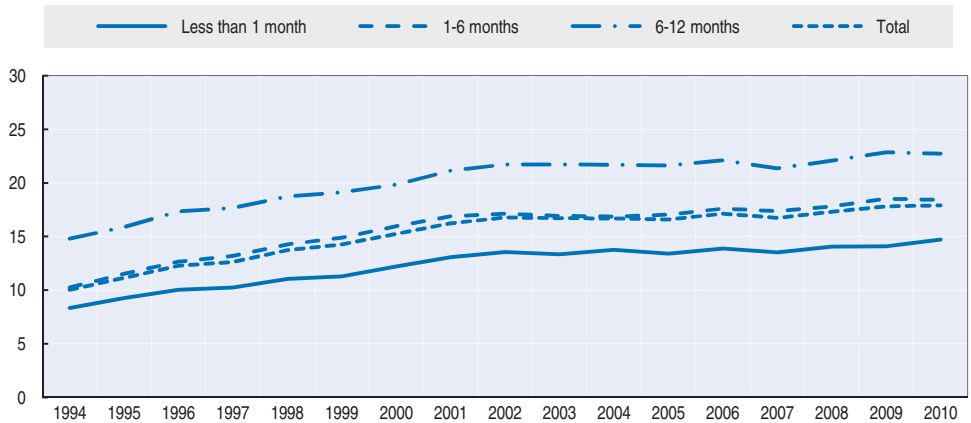
Long-term sickness absence is the main route to disability

Employees with sickness absence due to a mental disorder have, on average, a longer duration of sick leave. While the share of mental diagnoses in all sickness beneficiaries with long-term absences of 6-12 months is 23%, it is only 15% in short-term absences of less than one month (Figure 2.3). In 2010, 72% of all persons who were sick with a mental health condition had an absence duration of more than one month. Comparing 16 disease

categories, a Norwegian study found that, at 76 days on average, psychological problems show the third-longest absence duration (Aakvik *et al.*, 2010).

Figure 2.3. **Mental conditions are frequent among long-term absences and their share is increasing**

Share of mental health conditions in total sickness beneficiaries, by duration, 1994-2010



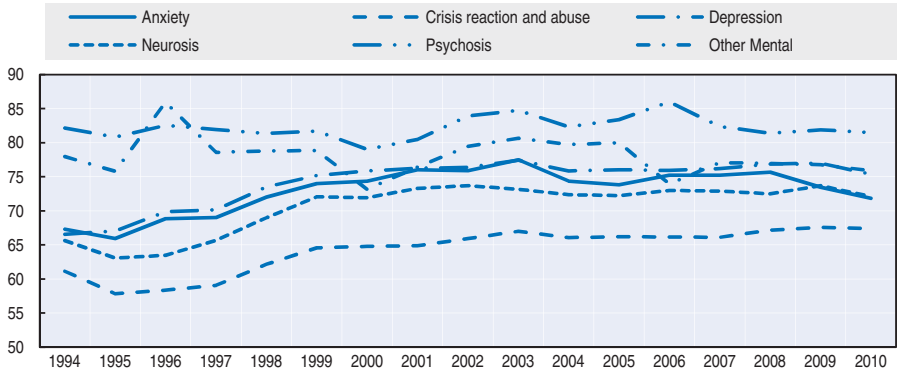
Source: Norwegian Labour and Welfare Administration (NAV).

Long sick leave is an important precursor of exclusion from the labour market and receipt of a disability benefit. Norwegian studies found that long-term sickness absences have a high risk of transforming into permanent disability benefits (Gjesdal *et al.*, 2004): about 25% of persons with a sick leave of eight weeks are granted a disability benefit within five years. For depression, for example, research shows a clear negative relation between sickness absence duration and return-to-work probability (OECD, 2012).

It is striking that anxiety and depressive disorders show such a strong increase of longer absences in the past decade (Figure 2.4). While the share of longer sick leaves among those with a severe mental disorder (*e.g.* psychosis) has remained stable at roughly 80%, the share of longer absences for anxiety disorders, neurotic disorders and depression has risen from 65% to 75%. In a rehabilitative perspective, sickness absence of a substantial duration should be restricted to conditions which have a direct negative impact on job tenure because they may scare co-workers in the case of a psychosis, or because they lead to complete work incapacity, *e.g.* in the case of a severe depression. In such cases, it is reasonable to treat and stabilise the acute condition first, and to prevent a negative dynamic in the workplace.

Figure 2.4. **Long-term absences have increased in common mental disorders**

Share of longer-term sick leaves of one month and over, by disease category, 1994-2010



Source: OECD questionnaire on mental health.

Long-term sickness absence often worsens the mental health condition

The dynamics of sick leave are complex; therefore it is important to differentiate sick leave behaviour of the healthy population from sick leave behaviour of vulnerable groups like people with mental health problems. Moderate and even sub-clinical mental health problems are on the whole enduring conditions, which can cause substantial work problems and disabilities if they are not recognised early and compensated by adjustments in the workplace. There is no necessity to stay away from work over a long period due to the mental health condition because the recovery process is often accelerated when people stay at work. In many cases, changes in the workplace or reduced performance requirements might be more effective than leave of absence. On the contrary, a longer absence from work may reinforce the mental health problem by enforcing avoidance behaviours in anxiety disorders, or by decreasing self-confidence. This conclusion holds for musculoskeletal or pain disorders in combination with mental health problems.

Sickness absence reforms face deep-rooted barriers

There have been numerous reforms and initiatives aimed at getting sick leave under control. However, the reforms seemingly fell short of the deep-rooted dynamics of sick leave. One factor is the cost of sick leave, with employers covering the costs only for the first 16 days of absence. This removes the financial incentive for them to actively promote an early return

to work. Another factor is the replacement rate of 100% during the first year of sick leave (with a ceiling slightly above average income, but for most employees collective agreements cover the difference). Hence, sick employees have limited financial incentives to return to work. Furthermore, there are differences in the strictness of the certifying physicians. Physicians who certify sickness absence feel more bound to their patients than to the public purse, which bears the majority of the sick leave costs (around 70% of all absence days in 2005; Biörn *et al.*, 2010). Patients with mental health conditions who fear problems when returning to work may ask their GP to extend the absence duration as well.

A range of reforms has aimed to reduce absence rates but have failed in this goal. The Inclusive Workplace Agreement (IWA), for example, a tripartite agreement between the government and the social partners first signed in 2001 aimed to cut sickness absence by 20% below the 2001 level. Despite being renewed several times, the IWA has arguably failed to achieve this goal.

A good working environment is not enough

Through the Working Environment Act, Norway puts a strong focus on a healthy and productive work environment which is controlled by the Labour Inspectorate. Moreover, employer counsellors from NAV have a preventive approach and emphasize the influence of the work environment. However, when it comes to employees with mental health conditions, a universal preventive approach is not sufficient to prevent sickness absence and disability. While some work-related factors can influence the risk and duration of sickness absence, *e.g.* family-friendly working hours or shift work, the predominant factor is the mental disorder itself and, to a lesser degree, the behaviour of the manager and co-workers and the generosity of the sickness benefit scheme (OECD, 2012). This hints to the significance of first, an early detection and treatment of the sick employee; second, individual support of the line manager who has to deal with a worker with a mental health problem; and last, financial incentives for all those involved to retain vulnerable employees at work. Putting the focus almost exclusively on working conditions falls short of dealing with the concrete workplace dynamics caused by a mental health problem.

The social partners are on the healthy peoples' side

Norway traditionally has a well-institutionalised social partnership, with the IWA being an important part of this collaboration. The social partners have taken the responsibility to improve sick-leave behaviour and job retention of workers with health problems, as well as to reinforce the

inclusion of disabled people into the labour market, yet their role remains unclear. While the exclusion of people with health problems from the labour market increases, employers increasingly rely on hiring foreign workers to fill labour and skill shortages, throwing some doubt on their willingness to substantially hire and retain people with health conditions. On the other side, unions act for their employed members primarily, and may be reluctant to push hard for the inclusion of people with mental disorders in a too assertive way, in order not to increase the work pressure on their members. Therefore, when it comes to mental health problems, both social partners have conflicting interests, although they generally have a supportive attitude towards the aims of the IWA.

The need for far-reaching reform

Sickness absence policy is a main strategic element regarding mental health-related employment issues, for three reasons: *i)* sick leave is the most frequent route into disability and often considered as a trap for permanent exclusion, especially for employees with mental disorders; *ii)* longer sick leave involves almost all relevant players, which offers the opportunity that solutions found in this field also affect the behaviour of the different actors in other areas; and *iii)* sick leave is usually the earliest moment to begin interventions and follow-up measures. Successfully addressing the high sickness absence rates in Norway is a necessary condition to tackle labour market exclusion due to mental disorders.

There are three fundamental barriers in the Norwegian sickness scheme: *i)* the lack of financial involvement of nearly all the relevant actors – employers, employees, physicians – in bearing the consequences of sickness absences due to a missing political will to impose far-reaching sanctions; *ii)* misconceptions and role conflicts of treating physicians; and *iii)* the common opinion that generous sick leave is beneficial to people suffering from ill-health, and contributing to preventing long-term absence.

A new responsibility and funding architecture for sick leave

Extending and restructuring employers' financing of sick leave

Employers only pay for the first 16 days of absence. With the average sick leave duration of 76 days due to a mental disorder this means the employer bears around 20% of the costs of an average psychiatric sick leave. Thereafter, financial incentives for the employer to ensure an early return to work are limited, despite formal obligations to prepare a return-to-work plan and engage in dialogue meetings. Hence, incentives are low for the employer to provide, upon the employee's return, workplace adjustments

including perhaps reduced performance requirements which can impose a burden on co-workers. Although an employer's behaviour is not only driven by financial incentives, experience in the Netherlands – where the employer has to cover sick-pay costs for two years with the possibility of a third year in case of non-compliance with the formal obligations – shows that a longer payment obligation for employers may substantially contribute to a reduction in sickness absence. The Netherlands experienced very high absence rates as long as the social partners could decide on sickness policies, while the entire payment liability fell on the public purse. Absence rates dropped sharply when financial responsibility was increased.

Both the magnitude and characteristics of financial incentives can have substantial effects on sickness absence patterns. In Norway, this was recently addressed in a discussion of whether the employer's co-financing period should be extended without changing the total amount of employer costs, by shortening the sick-pay obligation at the beginning in exchange for a small co-financing over the whole sickness period of up to one year. Thus, the necessity of financial incentives has been recognised, but without extending the total amount to be covered by the employer the impact is likely to be very small. The Norwegian experience which removed the employer's obligation to pay sick leave due to pregnancy shows that the 16-day wage-payment period does not reduce absences, compared to systems with no liability (Fevang *et al.*, 2011).

The current regulation is also problematic because it is only an incentive to avoid *short* absences. Consequently, employers are rarely financially involved in absences caused by mental disorders which tend to be long-term. Moreover, employers are hardly encouraged to support an early return to work for employees who are at a high risk of relapse, as is normally the case with mental health problems because the payment liability is renewed with each new sickness spell. This implies that employers only want employees with mental disorders coming back to the workplace when their health condition has been stabilised. Since such a stabilised state is usually not reached, keeping employees away from work may be the better alternative for an employer.

Arguments against co-financing do not apply for mental disorders

An often heard reason for shying away from substantially extending the employer's payment liability is the fear of minimising their readiness to hire applicants with a history of (mental) ill-health. Indeed, the reform of payment liabilities in the case of sick leave due to pregnancy shows that the complete removal of the employer's payment liability made young women more employable (Fevang *et al*., 2011). However, with respect to people with mental health problems, the situation looks different. First, hiring rates

of disabled people with a known mental health problem are already close to zero, and could hardly fall any further with a new liability system. Second, it is normally not known whether a job applicant suffers from a common mental health condition, making it very difficult to screen out people with such conditions at the moment of hiring. Third, prevalence of moderate or temporary mental disorders in the working population is so high that the labour market simply could not function without people with mental health problems.

Introducing co-financing by other involved parties

As long as absence from the workplace is financed largely by the state, other stakeholders will tend to remain somewhat passive. This can be harmful especially with regards to mental health-related sickness absences. Introducing co-financing of employees could support them to stay active, *i.e.* to remain at the workplace in spite of existing problems and address the problems. There is some evidence from research that a substantial part of sick leaves results from workplace conflicts or workplace situations which have deteriorated over time due to both the mental health problem of an employee and ineffective problem-solving behaviour of managers (Baer *et al.*, 2011). In such situations, the strain for the employee and his working environment, and the wish to escape the emotionally draining dynamics, is self-evident, even when work capacity still exists. Generally, the relationship between an employer and an employee is a crucial factor in the return-to-work process (Muijzer *et al*., 2011).

In the highly prevalent mental illnesses, such as moderate depressive disorders, somatoform pain disorders and anxiety disorders, there is a need for incentives which compensate for the intrinsic tendency of withdrawal from the workplace. These conditions typically include *i)* symptoms of reduced assertiveness and passivity; *ii)* excessive but inadequate treatment-seeking behaviour; and *iii)* fear-avoidance behaviour. The same often holds true for personality disorders, which typically lead to interpersonal conflicts at the workplace. These disorders need support, but not necessarily absence from the workplace over a substantial period. A Norwegian study found that fear-avoidance beliefs and inadequate illness perception are the main prognostic factors for return-to-work in sick-listed people with musculoskeletal and common mental disorders (Oyeflaten *et al.*, 2008). A Danish study also found that characteristics of self-efficacy, *e.g.* the fear of returning to work or a negative illness perception, can lead to inadequate return-to-work behaviour of the employee (Muijzer *et al.*, 2012). Avoidance behaviour not only has a negative influence on health but is also related to higher sickness absence (Penley *et al*., 2002; van Rhenen *et al.*, 2008).

Absences may not only be detrimental because they reinforce the symptoms of many mental disorders, but also because they add to workplace conflicts. In this respect, the generous sick-leave regulation in Norway can create substantial problems. The first three days of sick leave do not require a doctor's certification, and in half of all companies (those which have signed the IWA) the certification-free sick period is even eight days. Certification-free sick leaves may be used three times per year. Thus, employees can be absent due to sickness for five working weeks per year without seeing a doctor. Some sort of co-financing of (certified and non-certified) absences by the employee would help to avoid unnecessary or unnecessarily long absences. In this regard, a Norwegian analysis of sickness absence data shows that employees working in small enterprises with less than 20 employees have a 25% lower entry rate into sickness absence than those of larger enterprises (Markussen *et al.*, 2011). This suggests that workers working in companies that cannot tolerate a high level of sick leave are more likely to avoid absences.

Strengthening the compliance of the physicians

Certifying physicians are a third main actor in the sick-leave process. Physicians' certification practices have a significant impact on patients' absence behaviour, and there seem to be large differences between physicians (Markussen *et al.*, 2011). To date, various "soft" and "hard" measures have been installed to reduce sickness spells and to implement graded sick-leave certification among physicians: by defining graded sick leave as the default option; by educating doctors; and by implementing online tools providing comparisons of the certification behaviour of each doctor. There are also fines for doctors not compliant with the certification rules and even a possibility to withdraw the right to sickness certification. The latter, however, is an extremely rare event; hard measures are largely unused.

Withdrawal of the sickness certifying licence is perhaps too strong a measure. Most physicians view sickness certifications as a necessary but cumbersome duty, reducing the influence of such a sanction. In view of the critical role of physicians in the sickness absence process, another possibility to direct behaviours would lie in a specific co-financing liability, via third-party liability. This could be adequate where the sickness certification behaviour of a physician runs systematically counter to medical knowledge, *e.g.* in cases with full work capacity but prominent fear-avoidance behaviour. This would require clear guidelines for doctors on cases and situations in which a sickness spell would be contra-indicated.

Strengthening the commitment of the unions

Another relevant actor is the unions which have more than 1.6 million members and represent half of all employees in Norway. Unions are the third party in the tripartite IWA. Considering the large population of workers with mental disorders, a generous sick-leave system is not always in the best interest of the people concerned because it often leads to dismissal in the long run. There is evidence that unions have not adequately differentiated between the interests of different member groups, and are not willing to set specific priorities when it comes to health-related working problems. Job retention of people with mental health problems can only partly be improved by advocating for the general rights and benefits of employees. Unions should put more focus on the specific needs of the substantial subgroup of workers with mental health problems. Bearing some of the costs of excessive sick leaves, though this is difficult to implement in practice, could help to strengthen the focus on mental health within the unions.

A further reason justifying the strengthening of union obligations lies in the significance of their members' behaviours (be it managers or co-workers) in the case of employees with mental health problems. Working problems, sickness absence and any resulting labour market exclusion are processes which are often initiated by a mental disorder of an employee. However, the mental disorder does not fully determine the consequences on work capacity and job retention. Managers and co-workers often play an important part in how well such situations can be resolved. In view of the enormous stigma of mental disorders and the fact that such conditions are rarely disclosed, it is understandable that managers and co-workers may want to get rid of the problem by firing the worker with mental ill-health or encouraging him/her to quit. Unions and works councils could play a critical role in avoiding this.

New criteria for sickness benefit eligibility and non-eligibility

Absence from the workplace due to a health problem is an important measure in cases where the presence at work might be harmful to the condition of an employee or to his co-workers, or where the presence might substantially interfere with the recovery process. Reduced work capacity due to a health problem is another concept meaning that an employee cannot perform as well as before the mental health problem began. Finally, there is the concept of mental ill-health, meaning that an employee shows defined symptoms over a certain period. Although reduced work capacity, sick leave and ill-health are not congruent, they are often used interchangeably. Symptoms of mental disorders do not automatically transfer into reduced

work capacity and in case they do, there is normally no need for sick leave – but for other supports. Research shows that work is on the whole beneficial for mental health and recovery; therefore, sickness absence should be narrowed to the cases where the mental health condition requires inpatient care or rest at home.

Reconsidering eligibility criteria for sick leave

To implement such a new sick-leave practice, clear criteria regarding absence, as well as presence with reduced work demands, should be developed by physicians, employers and NAV and accurately evaluated. To support such a shift, implementation of new guidelines into the medical practice should receive greater attention: physicians' compliance should be monitored and, in case of non-compliance, sanctioned. Because a shift from absences to presences influences not only the employee concerned but also the workplace, employers need more training in dealing with employees with reduced capacities due to mental health problems. A significant advantage of a presence-based policy is that employers would be more interested to intervene when health-related problems are first perceived in order to avoid an escalation of the problems – knowing that these problems will not be solved by sick leaves. Moreover, a presence-based policy would support communications between the different stakeholders – employers, employees, treating physicians and NAV officers. Direct communication prevents the fragmentation of the approach and is a key factor in preventing long-term disability in people with common mental health problems (Pomaki *et al.*, 2012). Thus, more restrictive eligibility criteria for sick leaves will have a clear effect on employers too.

This also applies to the unions which would be asked to develop more actively measures that make their members more capable of dealing with co-workers with health problems when they are confronted with their presence and reduced performance. The expectation of an absence is part of the problem. Blocking the perspective of longer-term sickness absence from the beginning would enable both employers and co-workers to seek alternative solutions early on, not only when the problems have become so serious that sick leave and, ultimately, dismissal seem to be the only solutions.

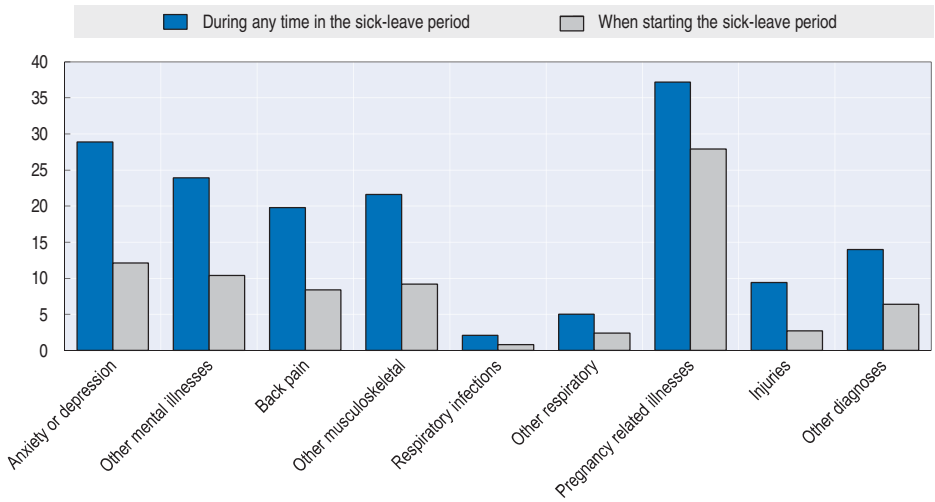
Partial sick leave often is an alternative to full sick leave

In the past few years, the application of *partial* instead of full-time sick leave has been strongly promoted in Norway, especially for frequent cases of unspecific back pain and minor mental disorders, resulting in a doubling of certifications for a partial sick leave since 1989. Nevertheless, the majority of sickness spells are still full-time. In mental disorders, the rate of

partial sick leave is 25%. This leaves room for improvement. However, mental disorders as well as musculoskeletal illnesses are among the conditions which are often certified as a partial sick leave in Norway (Brage *et al.*, 2011). Almost half of all partial mental health-related sickness certifications have been partial from the very beginning (Figure 2.5).

Figure 2.5. **Sickness leaves with a mental disorder are often partial leaves**

Share of partial sickness absences by diagnosis: at some point in time during the absence and at the moment of starting an absence (sickness absences started in 2009)



Source: Brage, S., I.C. Kann, A. Kolstad, J.P. Nossen and O. Thune (2011) ”Gradert sykmelding – omfang, utvikling og bruk”, *Arbeid og velferd*, Vol. 3/2011, Directorate for Work and Welfare, Oslo.

A recent analysis of NAV registers found that the increase of partial sick leaves was associated with a reduction in both sickness absence duration and the risk of sick leaves (Kann *et al.*, 2012). A 1% increase in the share of partial sick days corresponds to a 2% reduction in sickness duration. It is argued that the closer follow-up of physicians has caused the more frequent granting of partial sick leaves and the shorter leave duration. This suggests that recent activities to educate doctors have paid off. However, there are important differences in the share of partial sick-leave certificates by level of education and position (Kann *et al.*, 2012). Managers and highly educated people have roughly double the share of partial certificates (25%) than employees in low-skilled positions, *e.g.* nurse assistants (15%), cleaning personnel (12%) or shop clerks (13%). This points to the significance of working conditions and the role of employers.

Partial sick leave may not be equally effective in mental disorders

Although partial sick leave is more effective in terms of recovery and return-to-work than full-time absences, the intention of partial absences remains unclear. A reduced work capacity requires reduced work demands, but it does not signify that presence should be reduced. Thus, the target of increasing partial sick leave is at least partially misleading. The aim should be to avoid absences, at least for most mental disorders, but also for unspecific pain disorders which have a mental health component. In Norway, it is possible to be present at work with reduced work demands while sick-listed. This option should be applied more frequently and become the normal way of dealing with health-related work incapacity.

There is some evidence questioning the effectiveness of partial sick leave in employees with mental disorders. A Danish study showed that partial sick leave reduces the duration of the return to work of workers with physical disorders, but had no effect on the sickness duration of employees with mental health conditions (Hogelund and Holm, 2011). Both workplace dynamics and sick-leave behaviour of workers with mental health conditions seem to be different from other health conditions. Contrary to most physical disorders, mental disorders in the workplace are often related to workplace conflicts, a lack of understanding and prejudices on the part of the key stakeholders including the employee concerned to envisage a return-to-work solution.

Reconsidering the role of physicians in sickness certification

Sickness certifications are frequent in general practice. Around one-third of all mental health-related GP consultations result in issuing a sick-leave certificate (Mallen *et al.*, 2011). However, physicians perceive sickness certification as one of their most cumbersome duties (Wahlstrom and Alexanderson, 2004). Wynne-Jones *et al*. (2010) identified three main problem areas: conflicts, role responsibilities and barriers to good practice. The most common conflict is between a patient and doctor, especially in cases where the request for a certificate by the patient runs counter to the doctor's judgement, resulting in physicians issuing more certificates to those patients who are assertively demanding them. A recent survey of GPs in Sweden found that dealing with the expectations of patients concerning sick leave and the resulting conflicts is a main problem for physicians (Engblom *et al.*, 2011). Many physicians are aware that long-term absences may be harmful, but feel more responsibility towards their patients than to employers or social insurances. This is particularly frequent in mental health-related conditions which often result in a sickness certificate in order not to endanger the patient-doctor relationship (Norrmén *et al.*, 2008). Other

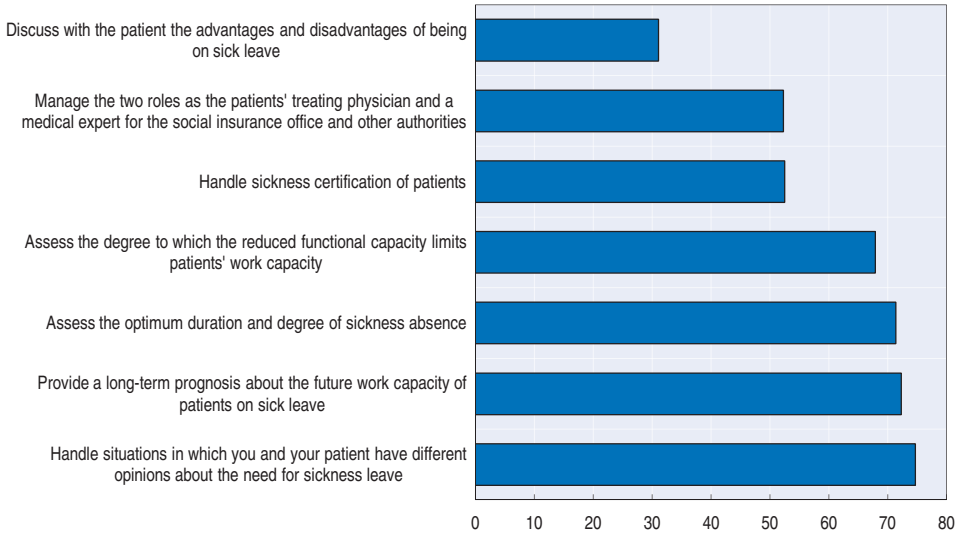
problems include communication with employers and insurance officers and the fear to break the patient-doctor confidentiality by giving information about the functional capacity of a patient.

Many GPs would prefer not to assume responsibility for sick leave certifications, pointing to the necessity to support physicians in handling the certification process by providing clear guidelines. Recent experience from Sweden shows that sickness guidelines can be very effective in supporting GPs, despite some initial reluctance in applying guidelines (Skaner *et al.*, 2011). One year after implementation, approximately three in four Swedish GPs used the guidelines, while other countries such as the United Kingdom or Norway have had mixed experiences so far. What has helped in Sweden was the frequently expressed need by GPs for having such guidelines, as well as the support in implementing them provided by medical associations.

Around 70% of a representative sample of GPs in Norway find it problematic to *i)* assess the degree of work capacity; *ii)* assess the duration and degree of sickness absence; and *iii)* provide a long-term prognosis about future work capacity (Figure 2.6).

Figure 2.6. **GPs perceive sickness certification as quite problematic**

Proportion of GPs in Norway (n=221), who perceive different sickness certification tasks and situations as problematic



Source: Winde, L., K. Alexanderson, B. Carlsen, L. Kjelgard, A. Löfgren Wilteus and S. Gjesdal (2012), "General Practitioners' Experiences with Sickness Certification: A Comparison of Survey Data from Sweden and Norway", *BMC Family Practice*, Vol. 13:10.

In other words, the large majority of physicians doubt the validity and reliability of their own assessment. Guidelines will be helpful but cannot solve the problem that work capacity cannot be assessed in a valid way by GPs because it also depends on many non-medical factors. As a result, full-time and partial sick leave should be restricted in favour of certifying no sickness absence at all – assessing the functional capacities instead and ordering other supportive measures in the workplace as needed. The degree and duration of longer sickness absences should not be assessed by physicians alone, but in agreement with the employer, the social insurance officer and where necessary a medical specialist. There is evidence that many GPs regard sickness certification in depressive patients as an important intervention being potentially therapeutic in its own right (Macdonald *et al.*, 2012).

Tightening the follow-up process by NAV

In a new tripartite agreement from July 2011, employers, unions and NAV decided to strengthen the rules in the cases of sickness absence in order to ensure earlier and closer follow-up and to stiffen the sanctions for the involved parties in case of non-compliance (see Box 2.1 above for more details). As such, NAV and the social partners have developed an elaborate and detailed process with a lot of potential. However, the schedule does not appear to have strong consequences. Analysis of the use of partial sick leave, for example, has shown no increase in the use of partial certificates around the follow-up meetings at (formerly) 8, 12 and 26 weeks (Brage *et al.*, 2011). Moreover, the scheduled activities are often not executed, thus there are problems with implementation and control in practice. In view of the frequent non-compliance with the rules, sanctions are either to low (*e.g.* the fine for employers of NOK 5 000) or, if more substantial, they are not applied in practice.

A main weakness in the process is the late involvement or the frequent non-involvement of professionals. Many employers will not be capable to set up a sound return-to-work plan for an employee with a mental illness, and many of those employees will not be able to contribute much to this plan either. In many cases, an elaborate follow-up plan for people with a mental health problem will require the involvement of a professional, in order to identify work capacity and necessary work adjustments for example for a worker with a depressive or an anxiety disorder. Doctors and specialists will often have to be involved in planning more actively and earlier. Not every case of sickness absence needs the presence of a physician, but in the existing process it remains unclear under what circumstances and at what moment when a physician should be involved.

This topic raises privacy and confidentiality issues. Currently, a doctor is only invited with the agreement of the employee. In most cases this will not pose a problem because workers see the advantage of involving their doctor. However, mental disorders go often hand-in-hand with a lack of insight risking the collaboration of all stakeholders. The supporting process should not be paralysed by typical characteristics of an illness, because it is exactly these disabling characteristics which should be compensated for by the follow-up plan. This suggests that in certain circumstances ways need to be found to circumvent employee obstruction to involve the physician *e.g.* by involving a NAV doctor or cancelling the sickness certificate.

The NAV officer is normally not involved before the 26th week of sickness absence. This creates two problems: First, this is very late in the case of mental disorders. Second, the NAV officer is the specialist for available rehabilitative measures. In most cases, such measures could, and should, be initiated before five months of sick leave. This means that the schedule does not take enough into consideration the differences between various groups of people on sick leave, confirming the need for differentiated criteria on how to intervene.

The detailed follow-up process does not change the problem that the process itself remains fragmented. The physician and the employee decide upon the sickness duration and degree, the employer and the employee work out the plan and the NAV officer decides on the rehabilitative measures. Although, in practice there is the possibility that all stakeholders take part in the dialogue meetings, the process does not systematically guarantee an integrated approach, which would assure that the assessment of the need for sickness absence, the details of the follow-up plan and necessary rehabilitation measures are based on the information and knowledge of all parties.

Summary and conclusions

Despite a series of sickness benefit reforms, sick leave is still unacceptably high. Sickness absence policy is a strategic element because sick leave is an important stepping-stone to permanent exclusion for employees with a mental disorder. One barrier against the decrease of sickness absence rates is that employers bear so little of the cost of absenteeism. They have to pay for the first 16 days of absence while the average duration of sick leaves with a mental illness is 76 days. Since employers, in view of the often fluctuating course of mental health conditions are reluctant to engage in return-to-work trials, their short payment duration runs counter to the integration goal. Due to the critical role of employers in the return-to-work process, the current structure of the

financial obligations is detrimental to the aim of employees with mental disorders returning early to the workplace.

As many sick leaves result from workplace conflicts, all actors – the employee, co-workers, the supervisor and the treating physician – may develop a wish to escape the emotionally draining situation. With respect to employees with a mental disorder, typical characteristics of the illness such as avoidant behaviour, an inadequate illness perception and passive coping strategies often reinforce the wish to escape the workplace situation. The 100% replacement rate in case of sickness absence supports a behaviour which may be a direct symptom of the mental disorder. Co-workers may also be relieved when an employee with a mental health problem does not come to the workplace. Therefore, unions should also have a stronger role in supporting job retention of the people concerned.

Norway has established a sound policy to increase partial sick leave at the expense of full sickness absence, including tough measures to sanction physicians in the case of non-compliance. However, the majority of sickness spells are still full-time and partial sick leave is not as effective in cases of mental disorders as it is in physical disorders because workplace dynamics and sick-leave behaviour of workers with mental disorders are different.

Physicians perceive sickness certification as a difficult task: there is often a patient-doctor conflict resulting in too many sickness certifications. Physicians also fear breaking patient-doctor confidentiality by giving information about the functional capacity of the patient to professionals and employers. Finally, most physicians do not feel capable to assess the optimum duration and degree of sickness absence and to provide a prognosis regarding the functional capacity. All this gets in the way of narrowing sick leave to the few cases where the mental disorder itself requires inpatient care or rest at home.

In a series of tripartite agreements, employers, unions and NAV developed rules to follow-up employees in the case of sick leave. These elaborate rules involving all parties have potential to improve the situation. But they need strengthening if they are to achieve the desired results. First, the existing sanctions should be increased and applied rigorously in practice. Second, physicians should be actively involved in return-to-work planning earlier and on a more regular basis. Third, the return-to-work plan should not be elaborated between lay persons (employers and employees) alone; physicians and NAV professionals should also be involved from the beginning.

Recommendations

- Increase the duration of the employer-paid sick-pay period substantially from 16 days today to at least around three months, or introduce co-payment over the entire sickness period and develop financial incentives for employers to retain employees at work.
- Reduce the replacement rate in case of sickness absence from 100% over one year to around 80%.
- Discuss the development of a financial stimulus for unions to support an active role in job-retention of employees with a mental disorder.
- Develop criteria to identify high-risk cases for a rapid intervention in the case of sick leave, with a regular involvement of the physician and the NAV professional in the follow-up process from the beginning.
- Expand early intervention training for line managers, and reinforce mental health-related intervention methods in the training curriculum of human resource managers.
- Develop transparent criteria on when full-time, part-time and no sick leave should be granted in case of a common mental disorder. Continue the training of physicians, strengthen the sanctions for systematically non-compliant physicians and apply them systematically.
- Base long-term sickness certifications on interdisciplinary assessments, involving GPs, mental health specialists and NAV professionals.
- Develop ways for employers, NAV professionals and physicians on how to co-operate closely in the case of non-compliance of the employee concerned, without violating the confidentiality principle.

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Chapter 3

Revising disability benefit assessment procedures and eligibility criteria in Norway

This chapter discusses the Norwegian disability benefit system and the possible reasons behind Norway's exceptionally high beneficiary rates. The experience with temporary disability benefits, which were merged into a new benefit in the meanwhile, is analysed. Recommendations are given with respect to the assessment process, the eligibility criteria, the funding of the system, and the actual application and implementation of existing rules and regulations.

Disability benefit as a frequent one-way road

Exceedingly high rates of people on disability benefit

In Norway, more than 10% of the working-age population receive a permanent or temporary disability benefit (Figure 2.1, Panel A). If people receiving a Work Assessment Allowance (a new benefit introduced in 2008 which comprises three previous benefits: temporary disability, vocational rehab and medical rehab benefit) were also included, this share would be almost 14%. This is by far the highest disability benefit recipiency rate in the OECD area. Unlike other countries like Austria, the Netherlands, Sweden, Switzerland or the United Kingdom, there has been no break in the increasing caseload of beneficiaries since the mid-1990s: beneficiary rates continue to increase from a high initial level (see Boxes 3.1. and 3.2 for more information on the Norwegian disability benefit and the Work Assessment Allowance).

For the past 15 years, Norway has had the highest spending on disability and sickness benefits in the whole OECD area. Spending on disability benefits has remained high at around 2.4% of GDP, more than double the OECD average, and sickness benefit spending has also been quite stable at around 2.4% of GDP. Taken together, Norway spends almost 5% of GDP on sickness and disability benefits, much more than any other country and 24 times the amount spent on unemployment benefits. This clearly indicates a strong shift of work problems to the permanent disability benefit system.

The share of disability benefits due to mental disorders is still modest

The share of disability benefit recipients with a mental disorder has risen significantly in most OECD countries in the past 15 years (Figure 3.1, Panel B). In Norway, this increase has not been very steep until a few years ago but the share increased by 10 percentage points recently. Today, mental disorders account for some 28% of all new benefit claims, compared with 30-50% in other countries. This suggests that many disability benefits are still being incorrectly granted for physical diseases (Mykletun *et al.*, 2006). With improving recognition of mental disorders by GPs, a further increase of diagnosed mental health-related disability is likely. Knudsen *et al.* (2010) demonstrated that symptoms of anxiety and depression are not only associated with subsequent receipt of a disability benefit in the long-term, but also substantially increase the disability risk for physical problems. Hence, official statistics are likely to underestimate the real impact of mental health problems on disability benefit recipiency.

Box 3.1. **Characteristics of the Norwegian disability benefit scheme**

Insured persons aged 18-67 whose work capacity is permanently reduced by at least 50% due to an illness, injury or disability are entitled to a disability benefit. The benefit consists of a basic, flat-rate element and a supplementary income-related element or a special supplement. The benefit levels are based on the reduction of the earnings capacity. A full benefit (worth around 66% of the previous income) is granted for an earnings-capacity reduction of 100%, while partial benefits are granted in 5% intervals for earnings-capacity reductions of 50-95%, with a proportional benefit payment. The disability benefit is granted on a permanent basis.

The health condition of a claimant is assessed by a physician, and reviewed by a NAV officer, sometimes together with a physician contracted by NAV. The NAV assessment comprises the application of a work-ability assessment tool, which also considers the medical information. There are treatment requirements as well, *i.e.* claimants must have made an effort to try adequate medical and vocational measures.

Box 3.2. **Characteristics of Norway's new Work Assessment Allowance**

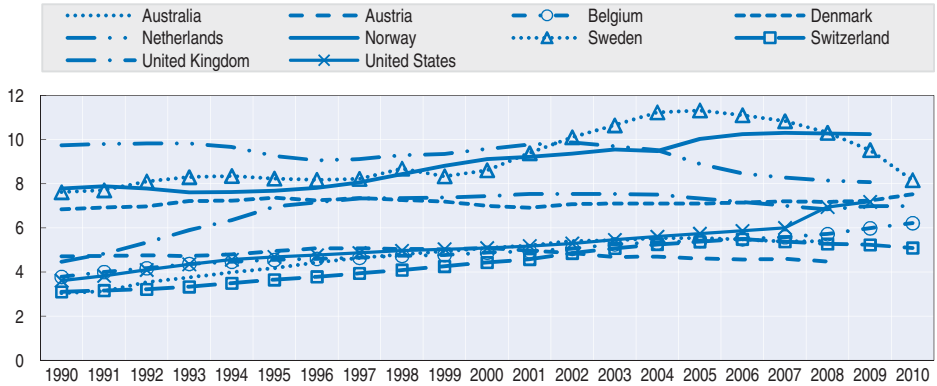
In 2010, three different benefits (vocational and medical rehabilitation benefit and temporary disability benefit) were combined into one, the Work Assessment Allowance (WAA). Under the WAA, a range of medical and vocational measures offered to persons who have a confirmed medical diagnosis and a reduction of work capacity by at least 50%, but still the potential of becoming employed or remaining at the workplace. The benefit rate is 66% of the last income, or the average of the last three years. Supplementary allowances are granted to compensate for expenses related to participating in vocational measures.

During receipt of the WAA the insured person must be "occupied" 37.5 hours a week, initiate treatment if needed and participate in an individual action plan and a rehabilitation and treatment plan. The rehabilitation plan is based on medical information supplied by the GP, discussions with the client, and often a work capacity assessment. There has been a discussion recently whether the latter should replace the still physician-based assessment procedure, yet there seems to be an agreement that both types of information are important. If clients do not participate in the rehabilitation plan, WAA can be withdrawn.

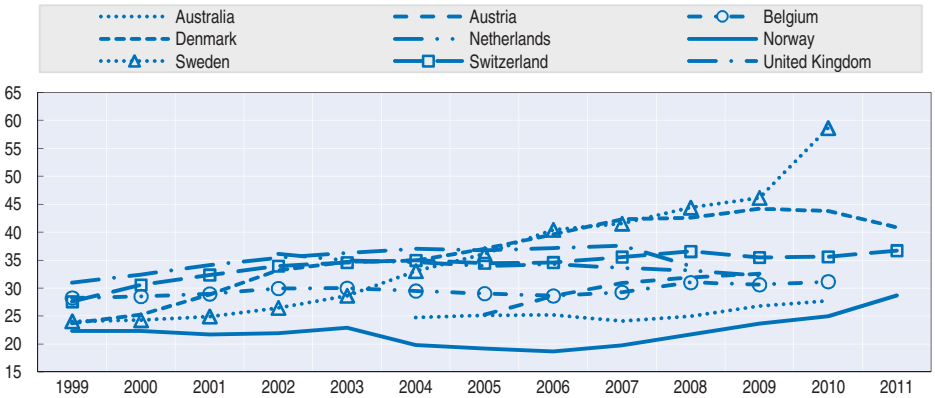
WAA can be paid for up to four years (or even longer if necessary). If measures provided under WAA do not improve the work functioning, i.e. work incapacity is still less than 50% and supposed to be permanent, a disability benefit can be granted.

Figure 3.1. **High and increasing disability beneficiary rates in Norway**

Panel A. Disability benefit recipients as a proportion of the total working-age population, caseload, all causes, 1990-2010



Panel B. New disability benefit claims due to mental disorders (in % of total claims) 1999-2011



Note: Norway includes the temporary benefit in Panel A, but not in Panel B. Sweden includes mental retardation, organic and unspecified disorders.

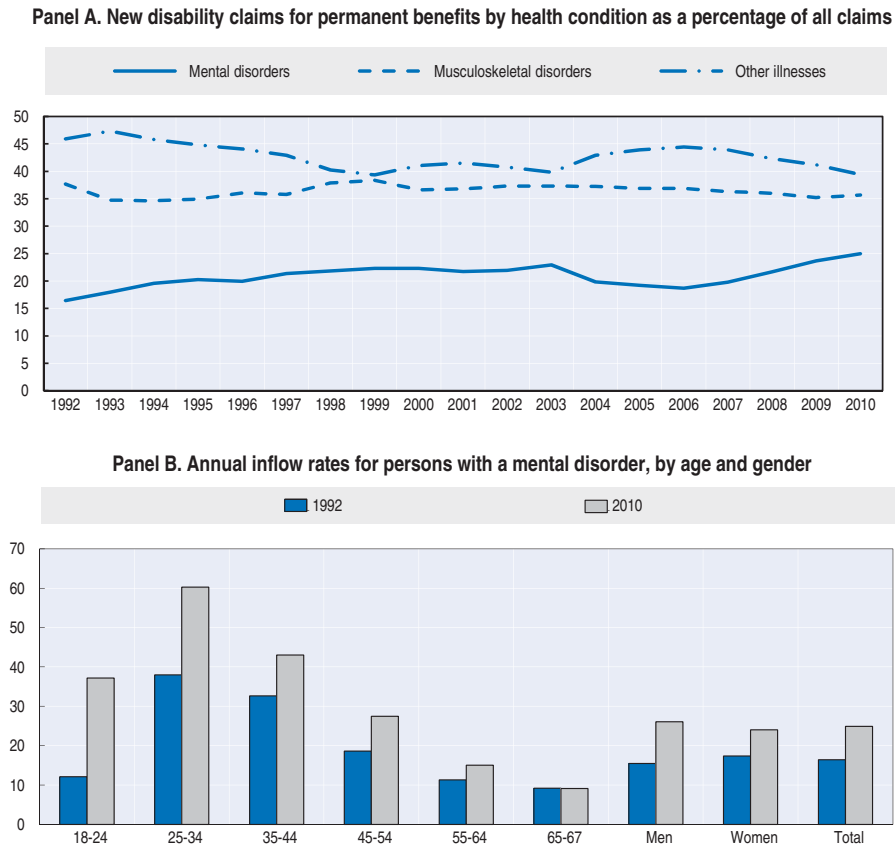
Source: OECD questionnaire on mental health.

In Norway, the increase of mental health-related disability benefits has not led to a decrease in benefits due to somatic causes; there was a parallel increase in psychiatric and somatic disability claims. Moreover, the stable disability benefit inflow rates for different health conditions, roughly categorised into mental disorders, musculoskeletal disorders and other diseases, suggest that the increase in the disability caseload is not due to

specific health-related factors but to general factors inherent in the Norwegian system (Figure 3.2, Panel A).

Age and gender-specific data show that inflows due to a mental disorder have increased in every age group (Figure 3.2, Panel B). It is noticeable that inflows have increased sharply between 1992 and 2010 for those aged 18-34.

Figure 3.2. **New disability benefit claims with a mental condition have increased in all age groups**



Source: OECD questionnaire on mental health.

Although disability benefits due to mental disorders have not increased disproportionally, some specific mental health reasons have. While the rates of substance abuse, schizophrenia and personality disorders have remained stable as a cause for disability, affective, neurotic and childhood mental

disorders have slowly increased since the mid-1990s. Hence, the recent raise concerns mostly common disorders like depression and anxiety and, since 2003, also acute stress reactions which usually comprise minor and temporary mental health problems. This development can also be seen in other countries.

Increase in disability benefit claims as a result of failure to implement strict reforms

The increase in the disability beneficiary population with predominantly moderate mental disorders from 1998 on is partly explained by a lack of political will to sustainably implement far-reaching reforms. Against the background of high claim rates prior to 1990, already in 1991 a comprehensive benefit reform began, aiming to restrict access to benefits by, amongst others, tighter medical criteria. This reform led to a decline in the overall inflow rate by 20-30% in 1990-95 among persons over age 45. However, in 1995 following a verdict of the Social Security Court, the regulations on the tighter medical criteria were largely annulled (OECD, 2003), resulting in an even higher increase in new claims in the following years.

This renewed increase in disability benefits led to the beginning of the "newer" reforms, initiated by the report of a Royal Commission in 2000, which again presented far-reaching reform proposals regarding the benefit system and the incentives for employers and employees. Government left it to the social partners to work out solutions. This led to the development of the Inclusive Workplace Agreement (IWA), the idea of which was to put the responsibility for job retention of employees with health-related incapacities more on the shoulders of employers. The IWA has not functioned by using sanctions or financial obligations, but instead is based on a largely *voluntary* educational approach with a range of government-funded measures. It is hard to find hard evidence for any effects of the IWA on disability and sickness absence in the past decade, even though sickness absence has decreased slightly in the past year. It is unlikely that there will be a substantial reduction in exclusion rates without also introducing some pervasive measures.

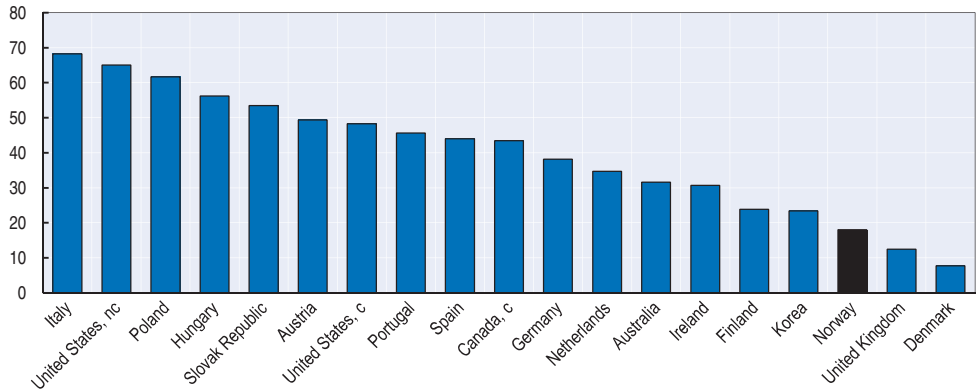
Disability benefit claims are seldom rejected

Some characteristics of the Norwegian social insurance system contribute to the current disappointing outcomes. While rates of new disability benefit claims are highest in Norway, rejection rates have traditionally been one of the lowest in the OECD. Only 18% of all disability benefit applications were rejected in 2008; this is an increase compared to 12% in 1990, but much lower than in most other OECD countries with rejection rates between 30% and 65% (Figure 3.3). This holds especially

true for applicants with mental disorders. Available data from Denmark, the Netherlands and Australia show that those people are less likely to be denied a permanent disability benefit than applicants with physical conditions (OECD, 2012). The situation in Norway looks similar: normally, people who apply for a disability benefit receive one. Consequently, the *exclusion error* (*i.e.* claims wrongly rejected) is rather small at the expense of a relatively large *inclusion error* (*i.e.* claims wrongly accepted).

Figure 3.3. **Norway has very low disability benefit claim rejection rates**

Share of rejected benefit claims among total applications, latest year available[a]



c: contributory benefits only; nc: non-contributory benefits only.

a. Data refer to 2004 for Poland, 2007 for Canada, Ireland, the Slovak Republic and the United States, 2008 for Finland, Hungary the Netherlands and Norway, 2009 for Australia, Denmark and the United Kingdom, and 1999 otherwise. Data for Ireland refer to persons applying for the Illness benefit after two years; for the United Kingdom to the long-term Incapacity Benefit and for Poland to KRUS pension scheme only.

Source: OECD (2003), *Transforming Disability into Ability. Policies to Promote Work and Income Security for Disabled People*, OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264158245-en Table 4.13; and OECD (2010), *Sickness, Disability and Work: Breaking the Barriers. A Synthesis of Findings Across OECD Countries*, OECD Publishing, Paris, http://dx.doi.org/0.1787/9789264088856-en, Chart 4.1.

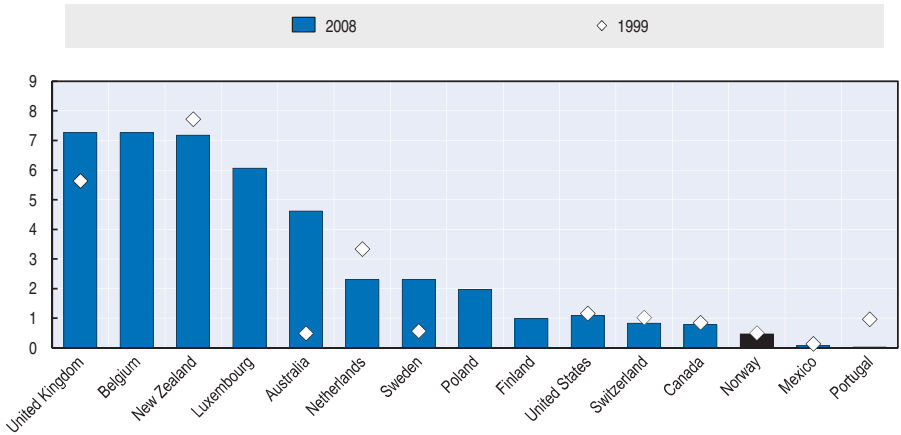
No outflow from disability benefits

Another problem is the *de facto permanence* of disability benefits. Outflow from a disability benefit into the labour market (complete transitions from disability benefit to employment, not including reductions in the grade of the disability benefit) is very low in Norway and, at 0.5%, lower than in most other countries with rates of 1-3% annually (Figure 3.4). In line with data for other countries, beneficiaries with a mental disorder are under-represented among benefit terminations. The low rate of benefit terminations in Norway is

related to the lack of reassessments of disability benefit entitlements. Although the pathway onto the disability rolls is long and participation in rehabilitative measures a precondition, there are no systematic assessments or vocational measures once a disability benefit has been awarded. The introduction in Norway of a temporary disability benefit in 2003 did little in this regard, because in practice these temporary entitlements were typically transformed into permanent ones at a later stage (OECD, 2010).

Figure 3.4. **Outflow from disability benefits into employment is close to zero**

Annual outflows to employment[a] as a share of the disability benefit caseload, 1999 and 2008[b]



a. Outflows include moves into employment and into other inactivity as well as loss of eligibility, but exclude deaths and transfers into old-age pension.

b. Data refer to 2004 for Luxembourg, 2005 for Australia and the United Kingdom, 2006 for Finland, 2007 for Canada, Poland, Portugal and the United States and 2008 otherwise. Data for Canada and the United States refer to contributory pensions; for the United Kingdom to long-term Incapacity Benefit; and for Poland to the contributory farmers' scheme.

Source: OECD questionnaire on disability and OECD questionnaire on mental health.

Applying existing disability benefit regulations as intended

The eligibility to receive a disability pension in Norway is related to the identification of a permanent reduction of the work capacity by at least 50%. With respect to mental disorders, the degree of the work incapacity is seldom stable, because of the intrinsically fluctuating course of several mental disorders but also due to environmental factors such as support at the workplace and the manager's behaviour. The assessment of the duration of a mental health-related disability is a difficult task. More than 70% of physicians regard already the assessment of the duration of a sickness absence as a difficult task, putting the validity of any assessment of a

permanent loss of work capacity into question. Therefore, *permanent* loss of earning capacity should be a rare event for people with a mental disorder which is not the case.

The onset of a mental disorder often lies in childhood or adolescence. Thus, it remains somewhat unclear what is meant by a "permanent loss of work capacity" starting much later in adulthood. Often, the work capacity reduction already existed but was compensated for or tolerated by the employer. The "loss" of work capacity for employees with mental disorders is often a virtual and workplace-specific loss created by a new imbalances, which may be caused by the working environment, *e.g.* by increasing demands in the workplace, the restructuring of a company or personnel changes. With respect to mental disorders, in many cases neither the criterion of "permanence" nor "loss" is clearly specified, putting the increasing disability rates in question.

The problem does not lie primarily in the eligibility criteria of the Norwegian disability insurance scheme which, in due course, require a real and permanent loss of working capacity caused by a health problem. Rather, in the case of psychiatric disability and also in the case of unspecific pain disorders, which are beyond the scope of this report, these criteria do not always seem strictly adhered to. This is problematic insofar as disability pensions, once awarded, are not systematically reassessed. As long as the beneficiaries do not claim vocational rehabilitation measures, or do not earn money, their status is not questioned. A system of permanent disability pensions may only function for a highly selected population complying with narrow eligibility criteria. The combination of non-adherence to strict eligibility criteria and permanent pensions leads to high and increasing exclusion rates.

Learning from the experience with temporary disability benefits

Two years ago, temporary disability benefit was integrated into the new Work Assessment Allowance (WAA), together with the medical and the vocational rehabilitation benefit. Nevertheless, the analysis of the practice of temporary disability benefits is useful. Being aware that many disabling health conditions are not permanent, Norway, as many other countries, has introduced temporary disability benefits. These benefits have often been used for people with mental disorders – their share on such benefit rose to 14% in 2007 compared with 8% of people with other health conditions. Above all, 20% of persons with affective disorders were on temporary benefits, but also 10% of people suffering from substance abuse or schizophrenia. In total, the temporary disability benefit caseload strongly increased from around 8 000 in 2004 when this benefit was introduced to over 48 000 in 2009. Temporary benefits may be a measure to avoid permanent exclusion, as long as they are not transformed into permanent

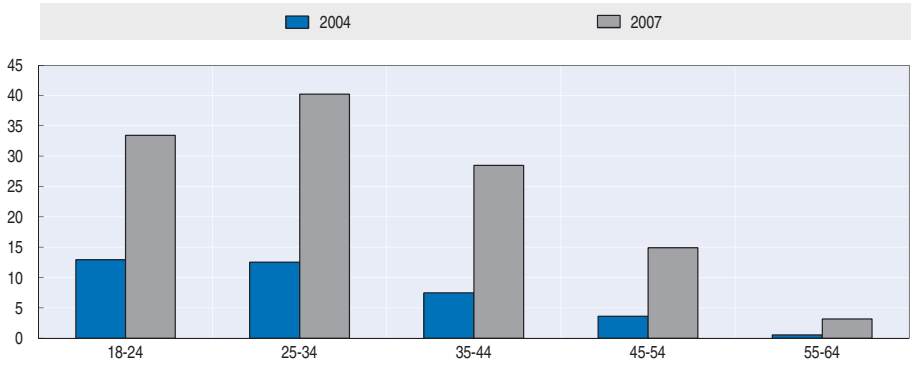
ones and used for rehabilitative measures. However, in all the years 2004-09 only 2-3% of those people on temporary disability benefit also received a medical or vocational rehabilitation measure. Correspondingly, the outflow from temporary disability benefits to employment was close to nil.

More generally, in view of the substantial duration of temporary disability benefits which could last up to four years, the purpose of such a "timeout" is not clear. For people with a mental disorder, being inactive during several years is in most cases detrimental to the persons' work capacity. Moreover, in Norway temporary disability benefits were granted in cases where it was expected that the work capacity of a claimant will improve, that is, not in the most severe cases with a pessimistic work prognosis. The almost automatic transfer from temporary to permanent disability for these more moderate conditions puts the entire temporary disability benefit system in question. This issue remains equally relevant for the WAA.

Temporary benefits were frequently granted to young adults before the age of 40 and to youth whose main indication is a mental health condition (out of 100 temporary disability benefits awarded to 18-24 year-olds, around 70 are granted due to a mental disorder). Looking at disability benefits with a mental health condition only, the following picture emerges: among the 18-34 year-olds with mental health conditions, more than one third of all benefits were granted on a temporary basis. This proportion declined strongly with age to around 15% for the 45-54 year-olds (Figure 3.5).

Figure 3.5. **Temporary benefits are rare for older people with mental disorders**

Share of temporary disability benefits out of all disability benefits in people with mental disorders, by age, 2004 and 2007



Note: Includes organic and unspecified mental disorders which are not included in the definition of mental disorders in the other charts.

Source: Norwegian Labour and Welfare Administration (NAV).

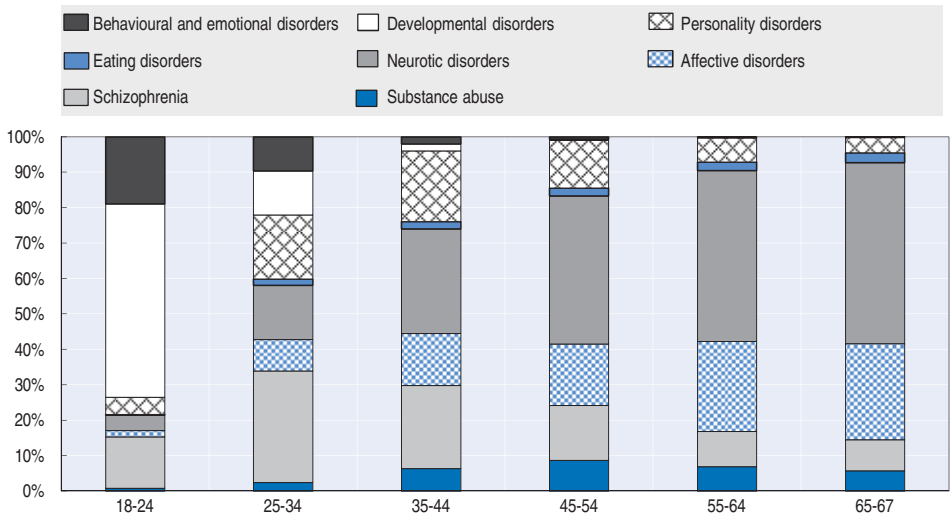
The older the disability beneficiary, the milder the mental disorder

The low share of temporary disability benefits in older age groups may be of substantial concern because older claimants on permanent benefits do not normally suffer from severe mental disorders (Figure 3.6). In the youngest age groups developmental and behavioural/emotional disorders are most prevalent, but the older the claimant the more frequent are depressive and neurotic disorders – ranging from 40% among 35-44 year-olds to 80% among those over age 55. The diagnostic composition of beneficiaries indicates that there would have been great potential for the use of temporary benefits in the older age groups. While severe developmental and early childhood disorders may often be quite permanent and disabling, this is not the case to the same degree for moderate neurotic or depressive disorders, which start later in life and do little to hinder labour market inclusion.

Thus, there were several problems with temporary disability benefits for people with mental disorders: *i)* they opened the gates to permanent disability benefits; *ii)* they did not seem to have a precise indication but were granted mainly in combination with young age and a mental disorder; and *iii)* they were not granted in the age groups where people with milder mental disorders and better previous work histories are highly prevalent.

Figure 3.6. **Moderate mental disorders are prevalent in older disability beneficiaries**

Share of different mental disorders in permanent disability benefits, by age, 2010



Source: Norwegian Labour and Welfare Administration (NAV).

Revising the disability assessment process

Benefit claimants normally have to pass three hurdles: *i)* a certificate from the treating physician; *ii)* an assessment of their work capacity; and *iii)* an interview with a NAV officer. The work capacity assessment is the basis for the interview with the NAV officer and is required not only in claims for permanent disability benefits, but also for measures under the WAA. Although the instrument is quite elaborate, covering a wide range of work-related aspects, it is a *self-assessment* filled out by the claimants themselves. This procedure corresponds to the strong emphasis generally given to user involvement in Norway. However, decisions about both granting disability benefits and in-take into vocational measures should not be based too strongly on self-assessments.

User involvement is a good basis for establishing a productive relationship between the NAV officer and the claimant, but the subjective assessment should be complemented by a multidisciplinary professional examination which should be the basis for the decision. Otherwise, the result of the assessment depends entirely on the ability of the NAV officer to make sound judgements on the basis of the medical certification and the self-assessment. However, this may be difficult if not impossible due to the uncertainties of medical certificates and the characteristics of mental disorders, often leading to biased judgements and self-perceptions – in turn resulting in, for example, a negative attitude towards one's own work ability, or in avoidant behaviour.

The potential bias against work in both medical and self-assessments is aggravated when the normal pathway into disability is considered. Most clients have passed through a longer period of sickness absence before claiming a disability benefit, with all the negative consequences of lacking activity on mood, energy, work-related fears and self-perception. Moreover, some mental disorders are inherently related to a lack of insight and sense of reality, resulting in an underestimation, or an overestimation, of work capacity. Thus, the administration of this central assessment tool should be reconsidered.

Strengthening the integration of medical services in the NAV offices

There is a general necessity for differentiating where there is a need for user involvement and self-assessment, and where there would be a need for specialist judgements. For example, user involvement is important in decisions dealing with the direction of actions. It has been repeatedly shown in research, and often emphasized by user associations, that employment and labour market inclusion is a predominant wish of jobless people with mental

disorders. On the other side, the methodology to assess working problems and potential, and to plan vocational rehabilitation processes, is a specialist task. In other countries such as the Netherlands, issues regarding work and health are examined by the occupational physicians. Also in Switzerland, specialised medical services assess the claimant's work capacity, while the rehabilitation plan is prepared by multidisciplinary specialists of the social insurance office, together with the treating physician and the claimant. Rehabilitative assessment and planning for people with a mental disorder is a specialised and multidisciplinary task, calling for a synthesis of the knowledge of the treating physician, the NAV physician, the NAV employment specialist and the former employer.

The NAV offices already employ insurance physicians, but there are only few of them and they are not allowed to see the claimant. This restricts their possibility to supervise the NAV personnel and revise medical certificates. Due to such qualitative and quantitative restrictions, the potential of integrated, multidisciplinary assessments and rehabilitation planning within the same office is far from exhausted. Moreover, such practices reinforce the fragmentation between treating physicians, rehabilitation professionals and the administration. Rehabilitation of people with health-related work incapacity needs an integrated approach. Expanding the number of insurance physicians in the NAV offices, extending their responsibilities as well as their rights in dealing directly with the claimants, and improving the status of insurance medicine in general might be effective in order to get a more reliable base for disability decisions and rehabilitation planning. Another possibility for the NAV offices would be to collaborate more closely with the local treating GPs as well as with the specialised psychiatric centres. GPs, who are mostly working in self-employed practices, might be partly employed by the NAV offices along the lines of the municipalities, which also employ GPs a few hours per week (see below).

Expanding the role of occupational physicians

A further option in the development of more adequate assessments of work capacity, in the sense of more employment-targeted medical examination, would be to involve occupational physicians. Today, occupational physicians in Norway are mainly concerned with the working environment, especially with environmental risks for the physical health of the employees, and they are not yet perceived as specialists in mental health issues, either by the employers or the unions. Nevertheless, occupational medicine combines work and health issues and therefore, would be well placed to play a much more active role in dealing with sickness and disability. Additionally, the ministries for both labour and health are

involved in occupational health services, facilitating an integrated approach on a policy level. Evidence from the Netherlands, where occupational physicians – instead of treating physicians – are routinely involved in cases of sickness absence, shows that such a model may help to decrease unnecessary sick leave. Moreover, such a model would ease the burden of GPs in activities they feel very uncomfortable with.

However, if occupational physicians were to take more responsibility in dealing with sickness and disability, they would have to focus more on early intervention instead of prevention and health promotion, and they should engage with health problems which are not caused by the working environment. They would also have to build up more competence in mental health-related problems and impairments in turn implying a need for occupational psychologist, the number of which is currently being increased also in other countries (*e.g.* Austria). Occupational medicine traditionally has had a toxicological approach suggesting that symptoms are caused by workplace characteristics (Henderson *et al.*, 2012). While this approach is effective for many physical occupational diseases, it falls short in dealing with multi-factorial mental disorders. Occupational health services are available in around 20 000 enterprises, covering some 50% of the total workforce (Lie, 2009). If occupational physicians were to become responsible for sickness certification, rehabilitation planning and disability assessment, they should be independent from the employers.

Involving more mental health specialists

It remains questionable whether GPs are sufficiently trained and informed to provide precise information about workplace problems and adjustments and necessary rehabilitative steps. This question notably arises in Norway where claimants with a mental disorder are mostly treated by GPs and not by specialists. Contrary to most physical impairments, the disabling consequences of mental disorders are neither easy to detect nor to compensate for. Regarding far-reaching decisions endangering social inclusion, such as prolonged sickness absence, rehabilitation planning and permanent disability, mental health specialists should be involved more regularly in the diagnosis and outlook of claimants with mental health problems.

Above all with respect to decisions about permanent disability, it should be a prerequisite that an adequate therapy to treat the mental health condition effectively has been provided, and that therapeutic possibilities to improve the work capacity have been exhausted. Since GPs themselves also complain about uncertainties in the treatment of patients with mental disorders, an adequate and exhaustive therapy usually is not feasible without, at least, support from the specialist mental health system. It should

be discussed whether a permanent disability benefit should ever be granted for a mental health condition, unless specialist treatment has been provided over a sufficiently long period.

Strengthening multidisciplinary assessments and rehabilitation plans

An adequate therapy has to be supported by a sufficient rehabilitation plan. Both adequate therapy and adequate rehabilitation need specialist knowledge. There is evidence from Norway that treatment possibilities have usually not been exhausted before a permanent disability benefit is awarded: 32% of the disability beneficiaries with a psychiatric illness have never sought treatment for their mental disorder (Overland *et al.*, 2007). What exactly could be meant by "exhausting" treatment options? While there are some diagnosis-specific guidelines about treatment of mental disorders, there are no such guidelines with regard to procedures integrating treatment and rehabilitation. In a country with a well-developed rehabilitation system, like in Norway, it would be worth developing integrated guidelines for rehabilitation assessment and planning.

Such guidelines might differentiate between the main groups of mental health-related impairments, mainly cognitive impairments (*e.g.* in schizophrenia), impairments of mood and drive (*e.g.* in affective disorders), anxieties and obsessive-compulsive symptoms (*e.g.* in neurotic disorders) and interpersonal impairments (*e.g.* in personality disorders). There is anecdotal evidence that in Norway, as in other countries, rehabilitation personnel neglects medical information – and vice versa – reflecting the fragmentation between the medical and the rehabilitative approach. This may be seen in the sickness absence certification practice whereby physicians often do not give sufficient consideration to employment issues of their patients, or in rehabilitative practice where professionals neglect the specific health problem, or ignore the diagnosis. Effective sickness certification and effective rehabilitation planning require an integrated approach.

Changing the character of disability benefits

The introduction of temporary disability benefits in Norway was an attempt to adapt to fluctuating disabilities and avoid permanent exclusion. However, the problem seems to lie in the existence of permanent disability benefits which, once awarded, are no longer reassessed. This creates two problems: *i)* the distinct possibility of receiving a permanent benefit without periodic reassessments undermines the usefulness of both temporary benefits and integration measures; and *ii)* the substantial working potential of many disability pensioners is wasted.

Closing the gate to disability benefit early on

The perspective of a permanent disability benefit is tempting especially for many people with a mental disorder but also people whose motivation to work is influenced by work-related fears. Against the background that people with working problems due to mental disorders are often working in low-skilled jobs offering only modest future perspectives, and often have distressing workplace conflicts, the option of leaving the labour market may become attractive. A rapid basic decision by NAV about the possible longer-term perspectives at the beginning of the rehabilitation process to close the gates to disability benefit would help people not to become unnecessarily passive early in the process.

Such a basic decision on whether a permanent disability benefit may be an option or not should be taken in the first two or three months after the initial contact with NAV – be it sickness absence or unemployment. An early decision to exclude the possibility of a permanent disability benefit (unless the health condition changes substantially) would be facilitated by a multidisciplinary assessment at the beginning of the rehabilitation process. A rapid decision on the general direction NAV actions should take might fulfil two targets: *i)* avoid unnecessarily long and frustrating rehabilitative measures; and *ii)* retain a work perspective. Both might help to avoid the somewhat paradoxical Norwegian system with long and costly vocational rehabilitation careers, often ending in permanent disability benefits. Taking a decision soon rather than awaiting uncertain rehabilitation results would also reflect that the rehabilitative success is, to a large extent, related to subjective expectations, and not only the result of objective work capacity. In Switzerland, for example, the introduction of a basic upfront decision about the general direction of the measures of the disability insurance has been an important contributing factor in reducing new disability benefits in the past few years.

Defining disability benefit exclusion criteria

Although eligibility criteria for disability benefits are not especially broad in Norway, they are not strictly followed in practice. Non-medical factors such as social background, education, socio-economic status, vocational position or employment opportunities as well as geographic factors play an important role in processes leading to permanent disability (Krokstad and Westin, 2004; Haukenes *et al.*, 2011). Obviously, a substantial part of the disability problem in Norway is an unemployment problem in disguise (Bratsberg *et al.*, 2010). Personality traits such as low emotional control or extrovert deviant behaviour, which are not clinical conditions in themselves, also predict disability benefit receipt (Knudsen *et al.*, 2012). Nevertheless, social and personal problems alone do not

qualify for a disability benefit. In order to be capable to take a rapid decision about a person's future disability status, it might be useful to develop medical and non-medical criteria which by itself explicitly exclude the receipt of a permanent disability benefit. In Norway, disability benefits are tied to a permanent and substantial reduction in work ability due to a health problem; legislation explicitly states that social and economic problems do not qualify for disability benefits. However, most mental health-related disability is caused by older people with minor mental disorders like depression and anxiety disorders, pointing to the importance of factors such as poor employment perspectives, older age and low education in the disability process.

There is evidence that a substantial part of all new disability claims in Norway, up to one-third, is a consequence of becoming unemployed due to firm downsizing or firm closure. Generally, unemployment is associated with subsequent disability, independent from personal or health-related factors (Stover *et al.*, 2012). Rege *et al.* (2009) showed that plant closure or downsizing between 1993 and 1998 increased a worker's likelihood of getting on disability benefits in 1999 by 25-30%; the aggregate effect of downsizing events increased disability rates in 1999 by around 15% among workers employed full-time in 1993. Bratsberg *et al.* (2010) estimate that displacement due to firm closure raises a worker's probability of claiming a disability benefit by 5-6% and that, overall, displacements account for 28% of all new permanent disability benefit claims by men and 13% by women.

Although unemployment may be harmful for mental health (including increased risks for depression and premature mortality), and although such situations generate a need to support people to find a new job or to rearrange one's own life, joblessness does not normally generate a causal health-related need for disability benefits. The link from displacement to disability is often not only established by a worsened health status, but also by reduced employment and earning perspectives, making the generous replacement rates of Norwegian disability benefits an attractive option, especially when one adds in the value of leisure. It would be possible to exclude adverse social and economic factors as a cause for permanent disability benefits, even if they may cause secondary minor and reversible health problems. The definition of such criteria would be in line with the current eligibility rules in Norwegian legislation: social problems do not qualify someone for disability benefits. The explicit description of such exclusion criteria would support the assessing authority in a stricter application of the legislation during the eligibility determination process.

Beyond concrete non-medical exclusion criteria, it might also be useful to define explicit *medical* exclusion criteria. This is partly the case in Norway already, because substance abuse without co-morbidity is not a

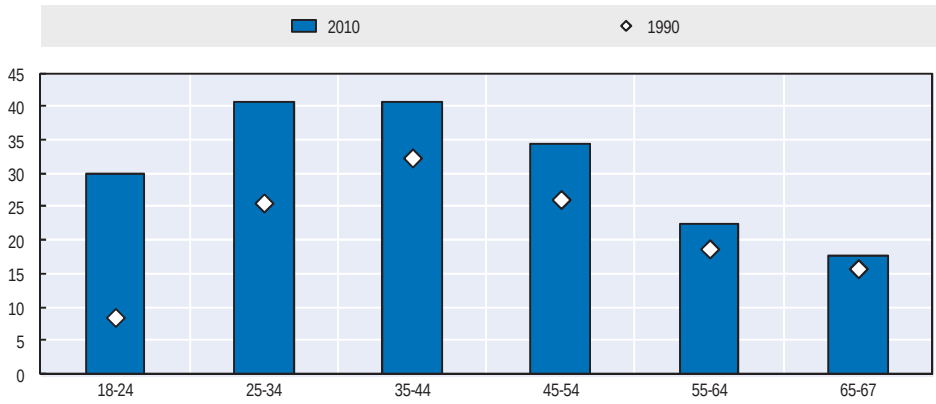
sufficient reason for a disability benefit. Moreover, neither depression nor anxiety alone without a co-morbid condition may be considered as qualifying for a disability benefit. It could be helpful to identify more medical exclusion criteria. Although an illness does not lead to a certain degree of work incapacity automatically, the diagnosis and other disorder-related characteristics such as severity, persistence, illness onset, co-morbidity or treatment response are closely related to the prognosis of the person's work capacity. Against this background, it would be possible to describe more precisely which mental disorders and which patterns of illness-related characteristics usually should not be considered as a cause for a permanent disability benefit, unless there are other important medical factors. It goes without saying, however, that these health conditions should qualify for prevention, early intervention and rehabilitation measures.

Considering a minimum eligibility age

A group especially vulnerable to exclusion due to a mental health condition are young adults. In Norway, the share of permanent disability benefits awarded due to mental disorders has more than doubled for the 16-24 year-olds between 1990 and 2010, although the minimum age for disability benefit was raised to 18 years in 1991 (Figure 3.7). For the 25-34 year-olds, the share has increased from 36% to 51%.

Figure 3.7. **Strong increase in the past two decades in disability benefits due to a mental disorder for young adults**

Share of permanent disability benefits which are due to a mental disorder, by age, 1990 and 2010



Source: OECD questionnaire on mental health.

This development has important consequences because people coming on the rolls at such an early stage will stay on disability benefits for up to 45 years. Thus, the youngest age group comprises only 5% of all disability beneficiaries in 2010, but it accounts for around 15% of all disability benefit years due to mental disorders. Conversely, while 27% of all new disability beneficiaries with a mental disorder are aged 55-67, they only account for around 10% of the total mental health-related disability benefit years.

Because there is no evidence that the "true" prevalence of mental disorders has increased in youth, it is far from obvious why more and more very young people receive a permanent disability benefit. Such a benefit is a wrong signal to young people, especially given the high uncertainty of medical prognosis about mental health-related work capacity. Since physicians already find it problematic to estimate the degree and duration of a mental health-related sickness absence over some weeks or months, it seems extremely unwise to award a permanent disability benefit at such a young age. It should therefore be considered to set a minimum age of maybe 35 or 40 years for awarding a permanent disability benefit due to a mental disorder, and instead focus strongly on medical and vocational rehabilitation of this group, an approach currently developed in Austria and Denmark.

Matching responsibility and funding structures for disability benefit

Currently, responsibilities and funding structures are unevenly distributed. Even if non-medical factors would be largely eliminated as a cause for disability benefit, they play an important role in practice. Bad working conditions or negligent managers' behaviour in the case of an employee with a known mental health problem may be crucial factors in the exclusion process from the labour market. However, employers do not have a relevant co-funding duty. The same is principally true for the municipalities, which are responsible for services such as primary health care or education, which play an important role in supporting vulnerable people. Finally, also the unions and employees themselves have a considerable impact on the outcome of health-related problems at work. Hence, disability costs should not be fully socialised, placing the entire payment liability on the public purse.

An obligation for employers to contribute to the disability benefit costs is self-evident, although mental disorders often start before people enter the labour force. Employers have wide freedom of action over how much they do to support employees staying at the workplace and how open they are in hiring applicants with mental health problems. Also with respect to the detrimental consequences of firm closure or downsizing, the labour market contributes to the burden of disability.

Municipalities should also be obliged to contribute towards disability benefit costs. Beyond economic and workplace-related factors, there is a broad range of risk factors for becoming disabled which are under the responsibility of the municipalities, *e.g.* educational achievement and school drop-out, early detection and intervention in integration problems of immigrants, rehabilitation and social assistance services, and primary health care services. Disability rates also reflect the effectiveness of municipal policies and services to give people a good start into working life and to support their retention in the labour force.

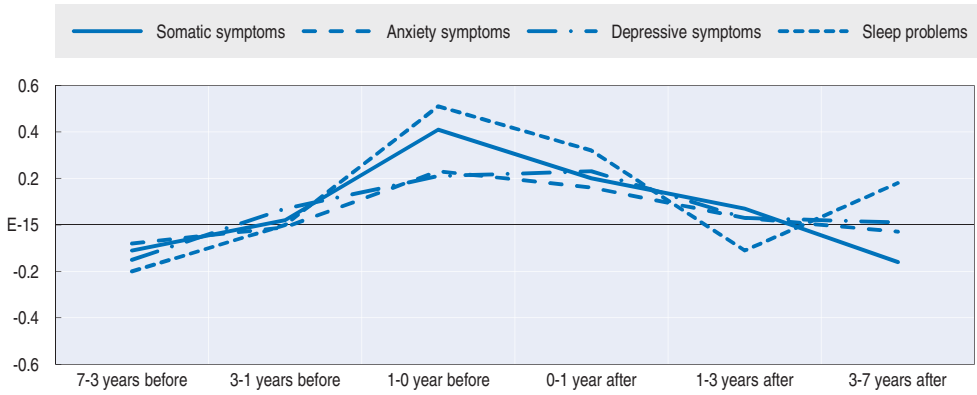
The extent of co-financing of disability as well as sickness-related costs by both employers and the municipalities should depend on the other elements of a forthcoming disability system reform. However, the contribution needs to be substantial enough to have an impact on the stakeholders' behaviour.

Introducing reassessments of disability beneficiaries

As long as permanent disability benefits are not limited to a highly selected group of people with severely and permanently disabling mental health conditions, beneficiaries should be reassessed on a periodic basis. The work capacity, as well as the health condition of people with a mental disorder, not only fluctuates but also improves after claimants have been awarded a disability benefit, as has been shown for Norway (Overland *et al.*, 2008) (Figure 3.8).

Figure 3.8. **Symptoms typically improve after disability benefit award**

Variation in different symptoms before, during and after disability benefit award (Z scores)



Source: Overland, S., N. Glozier, M. Henderson, J.G. Maeland, M. Hotopf and A. Mykletun (2008), "Health Status Before, During and After Disability Benefit Award: The Hordaland Health Study (HUSK)", *Occupational and Environmental Medicine*, Vol. 65, pp. 769-773.

The design of this study does not allow one to draw causal interpretations, but the health status several years after receipt of a disability benefit is almost identical to the health status several years before the benefit was awarded. This suggests that the disability assessment process, the duration of which is around three years on average, may well aggravate the illness symptoms. It can be assumed that without the endpoint of a generous permanent disability benefit in the social security system, which may seem very attractive to people with both health and work problems, symptoms would remain more stable. In this view, periodic reassessments should be introduced, changing the character of disability benefit from a permanent to a temporary benefit in most cases.

The substantial improvement in health status after the award of a disability benefit documents the great potential for reassessment. However, this health improvement is not likely to be seen during administrative reassessments, because they raise the same concerns and fears again as was the case during the examination of the original disability benefit claim. As long as there is a high probability to stay on benefits after an assessment as well as high uncertainty about successful return-to-work, beneficiaries will try to stay on the benefit roll. On the other hand, strict reassessments can identify substantial numbers of beneficiaries with work capacity, as experience shows in other countries (*e.g.* in the Netherlands, 40% of all beneficiaries were found to have at least partial work capacity or higher capacity that at the original assessment).

The low outflow in Norway from disability benefit back into employment seems related to the intrinsic damage the social insurance system is doing to people with mental health-related work problems. This is reflected in the behaviour of beneficiaries who rarely take active steps towards employment even if they would like to work. A Norwegian study on the long-term effects of return-to-work interventions for beneficiaries with musculoskeletal disorders (Magnussen *et al.*, 2009) found that, out of 899 beneficiaries, only one person had returned to full-time work after three years and 14 people had experienced small reductions in disability payments. The intervention (cognitive behavioural therapy and vocational rehabilitation) made no difference at all, nor did age, gender and time on disability benefits. This shows the detrimental effects of a permanent disability status in people who might be able to work at least partly, but who have fears, negative self-esteem and negative beliefs, which make them stick to a passive but financially secure life. The generosity of permanent benefits, combined with quite low financial incentives when partly returning to work, discourages beneficiaries to actively search employment, and finally, undermines the success of potentially effective vocational integration measures. This is confirmed by the beneficiaries themselves,

indicating that they have become used to living from secure benefits (Magnussen *et al.*, 2007).

Summary and conclusions

The number of disability benefits for psychiatric reasons has steadily increased in the past two decades in Norway, especially among young persons. Due to their high prevalence in young age, mental disorders account for the highest share of lost working years in disability beneficiaries. However, responsibilities for this development and funding structures are unevenly distributed. There are several problems leading to the high disability beneficiary rate in Norway and the increasing permanent exclusion of people with mental disorders from the labour market. First, the strict eligibility criteria are not really implemented leading to a very low rejection rate of claimants. Second, there is a widespread acceptance of disability benefit status as a final state which is supported by a lack of reassessment of beneficiaries.

Although the eligibility criteria of the Norwegian disability insurance scheme require a real and permanent loss of work capacity, disability benefits due to common mental disorders and among very young claimants have increased the most in the past. It is questionable whether it is adequate to *i)* make a prognosis of a permanent loss of work capacity for very young claimants; and *ii)* to diagnose a permanent loss of work capacity in older employees with a common mental disorder who have worked for years or decades despite an already existing mental disorder.

To further develop the assessment procedures, the integration of medical services in the NAV offices should be strengthened. Mental health specialists should be involved more systematically in decisions about both long-term sickness absence and permanent disability. Moreover, new benefit claimants should be required to undergo an adequate treatment of their psychiatric condition before a disability benefit is awarded. Finally, in view of the often improving health status after a benefit award, assessment should be an ongoing process in the vast majority of beneficiaries.

Systematic reassessment should not be viewed as an isolated measure, but rather be combined with the elimination of de facto permanent disability benefits. A lesson learned from temporary disability benefits in Norway is that integration-oriented measures and temporary benefits are severely undermined as long as there is a realistic perspective to receive a permanent disability benefit which, once awarded, will never be reassessed. Such a perspective can be especially harmful for vulnerable people with mental illnesses, work-related fears, working in low-skilled jobs, or having modest working perspectives.

Recommendations

- Apply the strict eligibility criteria for permanent disability benefits in practice and expand explicit exclusion criteria – including medical, social and socio-demographic criteria (such as age).
- Block the exclusion perspective as early as possible, where appropriate, by developing a rapid basic decision about the possibility to receive a permanent disability benefit. After a substantial time of vocational rehabilitation measures (of several years), the access to a disability benefit should be very restricted.
- Strengthen the treatment and rehabilitation requirements for claimants. Request adequate and specialist treatment before awarding a disability benefit including an active role in vocational rehabilitation. Avoidable non-compliance with treatment and dropout from rehabilitation should be sanctioned.
- Bind the award of a disability benefit to a professional interdisciplinary assessment including a mental health specialist. Develop guidelines for interdisciplinary disability assessment together with the medical associations and implement a systematic training for doctors in the use of such guidelines.
- Develop a substantial co-financing obligation of the disability benefit costs for employers and municipalities.
- Introduce regular periodic reassessments of the work capacity for most beneficiaries.

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Chapter 4

Enhancing the effectiveness of Norway's vocational rehabilitation system

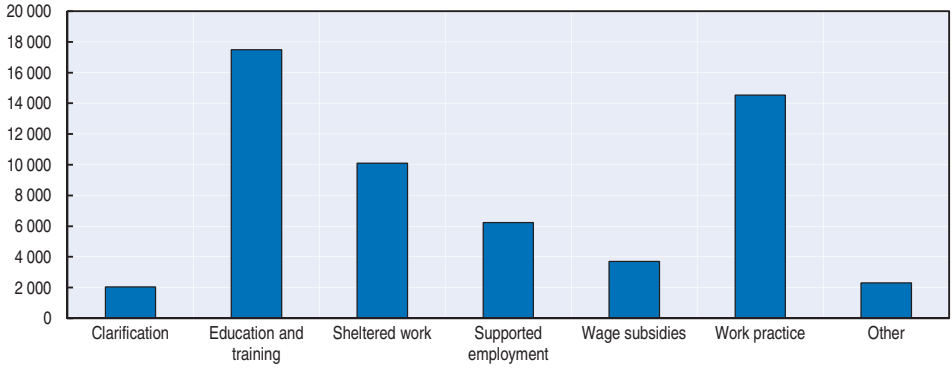
This chapter describes the use of vocational rehabilitation measures in Norway and discusses the effectiveness of these interventions for different target groups. Special focus is put on early intervention in the workplace, the support needs of employers and the role of the treating physicians. Recommendations are given on how the already sound vocational rehabilitation system can increase its effectiveness.

The current focus of vocational rehabilitation

Norway, in line with its work-oriented approach, developed a large array of vocational rehabilitation services ranging from sheltered workshops to training measures and supported employment. The number of participants in vocational rehabilitation measures increased from around 40 000 in 2000 to around 60 000 in 2011, pointing to strengthened efforts to support people to return to work. Generally training measures, including ordinary education measures, are the most frequent, followed by work practice, which can take place in regular companies or in sheltered workshops, and work in sheltered enterprises (Figure 4.1). Thus, the more traditional vocational rehabilitation measures which have generally been shown not to be very effective in bringing people into the regular labour market are still predominant.

Figure 4.1. **Training is the predominant vocational measure used in Norway**

Participants in different vocational rehabilitation schemes in Norway, September 2011



Source: Norwegian Labour and Welfare Administration (NAV).

However, the distribution of vocational rehabilitation measures in the main client groups – people with a mental or a musculoskeletal disorder – has significantly changed over the past years (Figure 4.2). For people with a mental disorder, work practice and supported employment are used more frequently nowadays at the expense of education and training, reflecting newer evidence of the higher effectiveness of workplace-based interventions including rapid placement and individual follow-up. The very low proportion of clients with wage subsidies is striking.

Figure 4.2. **The use of workplace-based interventions has increased**

Shares of vocational rehabilitation measures for clients with mental or musculoskeletal disorders

Source: Norwegian Labour and Welfare Administration (NAV).

Reconsidering the direction of vocational rehabilitation

Expanding the use of wage subsidies

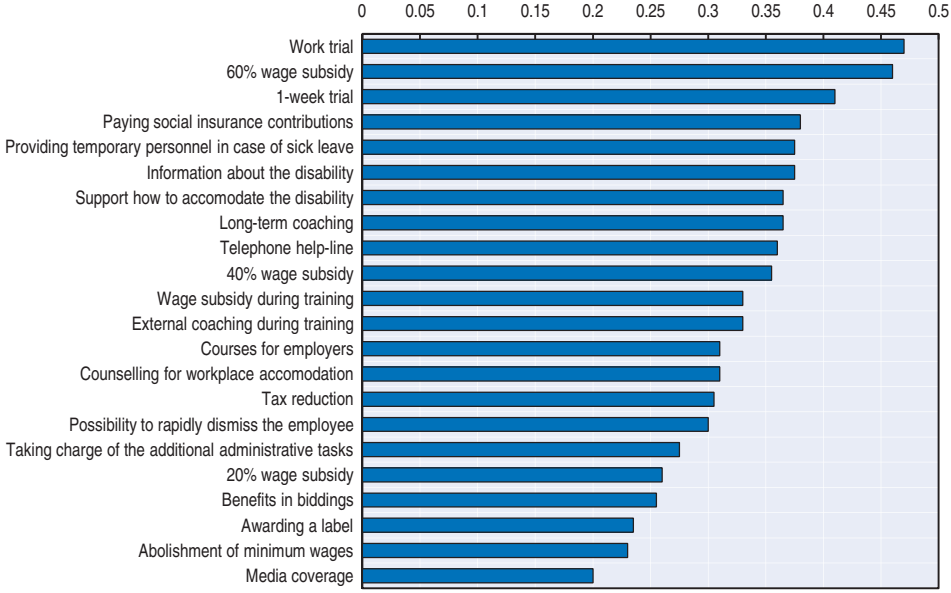
Wage subsidies could potentially help overcome the reluctance of employers to hire applicants with reduced work performance due to health problems, or to make strong efforts regarding the return-to-work of employees on prolonged sick leave. Wage subsidies to employers may not only be important to compensate for reduced work capacity, but also to compensate employers' feelings of uncertainty and fear, especially towards employees or job applicants with mental health conditions. This is especially true for the majority of small enterprises with less than ten employees. A Norwegian study (Westlie, 2008) found that subsidies have, by far, the largest effect of all vocational rehabilitation measures, increasing the employment probability by around 30%, compared with around 8% for vocational programme participation in general. However, despite their relative effectiveness, wage subsidies are seldom granted, with a share of only 7% of all measures.

In expanding the effectiveness as well as the use of wage subsidies, some preconditions should be fulfilled. First, the amount of the subsidy should adequately reflect the health-related reduction in performance, which is not yet the case. In a survey of 735 small and medium employers in Switzerland, respondents were asked which supports would increase their

willingness to hire people with a disability. The most frequently stated supports were measures which reduce the employer risk, including substantial wage subsidies, followed by individual follow-up through competent professionals (Figure 4.3). A 60% wage subsidy would improve the employment probability of persons with a disability by around 45 percentage points, a 40% wage subsidy by 35 points and a 20% wage subsidy by 25 points.

Figure 4.3. **Response by SMEs to alternative measures to boost the hiring of people with a disability**

Percentage-point improvement of the willingness of small and medium employers to hire people with a disability for a range of alternative employment measures, relative to the present situation



Source: Baer, N. (2007), "Würden Sie einen psychisch behinderten Menschen anstellen?" (Would you hire a person with a psychiatric disability?), *Zeitschrift für Sozialhilfe*, Vol. 1/2007, pp. 32-33.

But financial compensation is not the only concern of employers. They rank work trial and a free one-week trial as equally important as a very high wage subsidy, reflecting their uncertainty when hiring an applicant with a disability. Further important measures according to this study *i)* information about the disability and how to cope with an employee with such a disability; *ii)* existence of a continuous follow-up of the employee by a professional; and *iii)* a telephone helpline in cases of emergency. These

results show how important it is for an employer that employees with health problems are professionally taken care of in a reliable and sustainable way.

Being *in-work* rather than *out-for-work* financial support, wage subsidies may be the better alternative to a partial disability benefit. A wage subsidy gives another signal than a disability benefit. However, wage subsidies are more easily open to misuse and reaching the right target population can be difficult. This is for example the case for the flexjob scheme in Denmark which, due to its rules and generosity, encourages employers to claim subsidies for employees they would have hired or retained anyway. In order to prevent misuse of wage subsidies, such subsidies must be targeted in such a way that they *i)* replace partial benefits, and *ii)* are not granted for people employable without a subsidy.

Reconsidering the functions of sheltered work

Beyond education and training measures, work in sheltered enterprises or in vocational rehabilitation enterprises is a common measure in Norway's vocational rehabilitation system. The goals of work in a sheltered environment vary from assessment of the work capacity (clarification, for up to 12 weeks), training in work skills and qualification (up to two years), to gaining work practice (up to 20 months). There are more than 300 non-profit enterprises in Norway offering permanent or temporary work opportunities for clients referred by NAV. Sheltered enterprises are provided by the municipalities, and often well integrated in the local environment. However, with respect to people with mental disorders, there is a large body of evidence showing that work practice or training under sheltered conditions is not an effective measure in terms of competitive employment outcomes. Westlie (2008) demonstrated that work practice in sheltered enterprises had no employment effect at all, contrary to work practice in regular companies which increased the employment probability by about 6%.

Although there is a group of persons *without* a realistic perspective in the open labour market and in need of a permanently adapted workplace in a sheltered environment, it remains doubtful whether work training over months and years in such an environment yields positive results. In respect to people with mental health conditions, the question arises as to what kind of "shelter" is really needed. Persons with mental disorders usually need shelter in the form of a trusting and sustainable relationship with a specialist, who guides them through uncertainties, problems with self-esteem, workplace conflicts, etc. but they do not need all tasks to be undemanding. Furthermore, a well-known basic problem has always been that improvements achieved in a sheltered workplace are hardly ever transferred into a new environment in the regular labour market. As a result, sheltered work often leads to a cutback of one's expectations and a regression to a

lower level of functioning due to decreased self-confidence. Thus, work practice aimed at supporting people to become employed in competitive settings should not take place in sheltered enterprises.

Sheltered enterprises in Norway are, by regulation, joint-stock companies with a municipal majority ownership (by one or more municipalities with the latter being quite common). Private companies may join as minority owners. Funding of labour market measures is channelled through the governmental part of NAV. The county branch of this body buys services from the sheltered enterprises for the municipalities in the county collectively, with limited or no competition between enterprises. Some of this acquisition is made through long term contracts. What measures to use within the available services is a matter of discretion and decided by the local NAV office, which, in most municipalities, has a municipal part imbedded. In this complex setting, it might be useful to set clear guidelines and to give more guidance about which local services and rehabilitative concepts should be built up for which clients.

Enhance qualification – if necessary

In 2004, training schemes and education accounted for 60% of all labour market measures, predominantly classroom education in ordinary and private schools and universities, with a maximum duration of three years. However, the role of education has become less significant for participants with mental health conditions and is now around 35%. There have been doubts regarding the effectiveness of educational measures. Reviewing active labour market measures, Roed (2012) found that traditional training measures perform rather poorly with respect to employment. The small rise in employment probability does not compensate for the slower transition to work and the administrative costs of the programmes. There are three additional problems. First, people with compulsory qualification only are under-represented in education measures, while those with higher education are over-represented (Westlie, 2008); hence, most education measures have a focus on re-education. It is questionable whether re-education is always useful for people with mental disorders. Second, ordinary educational courses have a long duration leading – in combination with an already long duration since the last work experience (sick leave, waiting time until the measure starts) – to a very long absence from the labour market. Moreover, short-term effects on employment are low, leading to an additional period of labour market absence. Third, educational measures are rarely combined with other vocational measures, resulting in an increased probability to face problems during the transition to the labour market. Thus, it is doubtful that significant investments should be made in education measures. There is a

large body of evidence showing that supported employment measures are much more effective than re-education and training.

Contrary to the general education measures, the NAV offices have provided for some years now a so-called qualification programme targeted mainly at younger people without higher education. This programme was started against the background of the high numbers of youth who were neither in school nor at work and considered as living in difficult situations. Young people coming to NAV without a certified diagnosis or work experience, but often with complex social needs, can be provided with a support programme. NAV supports these young people to get into education and treatment if needed. General activation and first steps towards education and work are the main goals of the qualification programme, which is often used by persons with an immigrant background. According to recent results provided by Statistics Norway, about 20% of participants are in some kind of work at the end of the programme, which seems a positive outcome given their vulnerable starting position. In view of the large number of people with a mental disorder in the qualification programme, it might be possible to increase its effectiveness by introducing a sound interdisciplinary assessment of both their mental health and social needs.

Extending supported employment at the expense of the coaching intensity

Supported employment measures have increased significantly in the past few years across most OECD countries, especially for people with mental disorders. This measure follows the principles of rapid job search instead of longer periods of assessment and training, targeting normal jobs in the regular labour market instead of work in sheltered settings and offering support unlimited in time. In Norway, supported employment measures often end when a job has been found, the normal duration being six months with the possibility to extend follow-up for a further six months, rising to three years in special cases. Terminating individual follow-up processes at the moment of the job placement in many cases endangers the success of this measure. For employers, especially in small and medium-sized companies, the lack of ongoing support for newly hired employees with a mental disorder is a main cause for their reluctance to engage more in integration.

For mental disorders, the biggest challenge generally is not to place people in the labour market but to retain them at their workplace. Vocational measures which end with job placement run the risk that a lot of energy, time and money are lost. To raise the effectiveness of supported employment measures and the sustainability of employment found,

follow-up supports should generally be offered for an unlimited period. In most cases these supports do not need to be very intensive, and would therefore cost little relative to the potential gain. Once a relationship between the client and the counsellor has been established at the beginning of the process, the frequency of contact will decrease substantially. It might be possible to develop models of supported employment providing lower contact intensity in the beginning in favour of a much longer time frame.

Making the most of a strong rehabilitation structure

The merger of social insurance and unemployment services, with strong integration of social assistance into local NAV offices, has created a significant potential to increase the effectiveness of vocational rehabilitation. Due to the one-stop-shop nature of these offices and the responsibility for all employment measures, NAV has the possibility to steer integration. The NAV offices are involved from the beginning and over a long time, and they can offer integrated and co-ordinated vocational measures for all persons in need – independent from their status of being unemployed, on social assistance or having a health problem. However, this potential is not yet fully used.

Defining target groups and developing criteria for certain services

Although there is some practice of so-called programme chains, whereby different measures are combined sequentially according to individual needs, there is a lack of evidence-based criteria for the use of particular rehabilitative services or a combination of such services. It is, for example, not clear which rehabilitative measure might be needed by different groups of the mentally ill. The broad range of rehabilitative possibilities, the strong work approach and the generous framework suggest a need for developing targeted and evidence-based rehabilitative programme packages for different target groups.

There is also a lack of criteria for targeted interventions in the case of early sickness absence. Due to both a very large number of employees on sick leave and the lack of early intervention criteria, the first NAV intervention does not take place as early as needed in the critical cases. Person and situation-related criteria are needed to identify sick-leave cases which cannot be left to the employer and the employee, but should involve the NAV officer earlier. The initial sorting and the individual assessment offer opportunities for integrating such intervention concepts.

Rehabilitation or disability – setting the course much earlier

The generous rehabilitation framework, offering measures over a period of four to five years and the broad range of sophisticated and client-centred vocational measures need to be seen against a substantial dropout rate from rehabilitation – especially among clients with mental disorders – and a frequent recourse to disability benefits. The evaluation of a promising NAV project named "Where There's a Will – Focus on Work and Mental Health", started in 2004 to increase the participation of people with mental disorders in the labour market, concluded that many people drop out during rehabilitation (Norwegian Ministry of Labour and Social Integration and Norwegian Ministry of Health and Care Services, 2009). There are some regulations in NAV on possible sanctions for claimants when they do not comply with the rules (*e.g.* removal of the benefit). However, sanctions are rarely applied, aiming to preserve a positive and motivating circle with the client, while enduring non-compliance may lead to dismissal from the rehabilitation benefit. It is striking that – due to the work-first approach and the high rehabilitation dropout rate, as well as the moderate rehabilitation effectiveness – a lot of claimants eventually receive a permanent disability benefit after having undergone up to five years of vocational rehabilitation and an additional year of sickness absence.

The possibility of receiving a disability benefit after having been awarded several vocational rehabilitation measures undermines the success of such these measures. Therefore, it is worth considering if it is possible to set the course right at the beginning, *e.g.* by carrying out a general assessment within the first months after the initial contact with NAV, to determine whether a claimant – with respect to prognosis of the work capacity – is likely to be eligible for a permanent disability benefit in the future. Although it will not be possible in all cases to take such a definite decision, it will often be possible to rule out the necessity of a disability benefit. This would support claimants to concentrate on rehabilitation, and to actively stay in programmes.

Sickness-absence interventions do not replace early intervention

A relevant advantage of the Norwegian labour and welfare system is the comprehensive responsibility for vocational rehabilitation and intervention in prolonged sick leave, where NAV professionals come in, inviting the other actors to a so-called dialogue meeting within the first 26 weeks of sick leave. However, the majority of employees with mental health-related work problems are not absent but are present at work, frequently at the expense of lowered productivity, workplace conflicts etc. There is some evidence that sick leave is not a very good indicator for mental health-related problems at

the workplace, both due to its relatively low prevalence and the late beginning of sick leave (Baer, 2011). The most prevalent, as well as the earliest indicators of mental health-related problem situations in the workplace, are interpersonal conflicts, worsening working behaviour and performance problems. Sick leave usually is the preliminary endpoint of a negative development at work.

Health promotion and prevention do not replace targeted intervention

Correspondingly, there are a lot of health promotion as well as disease prevention and safety activities taking place in Norwegian enterprises as a consequence of the Working Environment Act. Furthermore, the agreement on inclusive working life generally aims at preventing health-related absences and exclusion from working life. For enterprises which have signed the co-operation agreement, NAV offers special services, *e.g.* a contact person in a NAV working life centre supporting the enterprise in preventing sick leave and providing relevant information. Enterprises in industries with known high-risk factors in the working environment are obliged to have a health service, and usually occupational health services have a strong preventive focus as well. The same applies to the labour inspection authority, which controls all enterprises, and which has a predominant focus on prevention of both diseases and exclusion, as well as on health promotion. Thus, the overarching goal of all health-related activities at the workplace is to prevent ill-health caused by physically or psychosocially unhealthy working conditions. This is usually done by general activities for all employees or managers, *e.g.* information campaigns, courses, or the implementation of processes which ensure the correct procedures to be followed in the case of sick leave.

Taken together, there is a broad range of activities, measures, regulations and actors in place in both general prevention and individual rehabilitation, including interventions in prolonged sickness absence. However, there is a wide gap between general prevention and individual rehabilitation, with nobody being responsible for identifying and intervening in existing mental health-related work problems. Given the early onset of mental disorders, general preventive activities in the workplace are not targeted enough to have a strong effect on the manifestation of mental health conditions. Generally, it would be too simple to assume that mental health conditions are usually caused by an adverse working environment. As a result, the majority of employees with a mental disorder, who are at risk of dropping out of the labour market but still present at work, are so far not reached by the existing measures.

Targeting the functions of the Employer Support Centres

Other important actors in the system are the Employer Support Centres (formerly Working Life Centres), which already narrowed their role to supporting employers in dealing with health-related problems in the workplace. These centres have an emphasis on health promotion too, *e.g.* trying to motivate human resource staff in enterprises to engage more in health promotion. The centres have a strong information as well as awareness approach, aiming at educating employers about the stigma of mental disorders, normalising mental health problems and informing them about the available professional support systems for people with mental health conditions. Recently, the centres have started a very promising trial scheme providing advisors for work and mental health issues; this is now available in seven counties. These advisors may also be contacted directly by employers in concrete problem situations, *e.g.* to give advice about possible work adjustments. However, this does not appear to be the main task of the centres. Altogether, the potential of the employer support centres does not seem to be exploited fully.

Employer support centres provide a good structure to systematically offer early interventions at the workplace at a high competence level. The centres have already built numerous contacts with employers which could be expanded, deepened and systematised. The aim should be to become involved, as early as possible, in all workplace situations where mental health-related work problems are identified, to counsel employers on how to handle the situation, and to get in contact with the employee if necessary. To fulfil these early intervention tasks, the centres will need to be better resourced and staffed. To be able to achieve early intervention at a high competence level, the teams in the centres should be multidisciplinary, including psychiatrists and psychologists, or, alternatively, should collaborate very closely with the specialised psychiatric institutions, *e.g.* the District Mental Health Centres.

Linking expanded early intervention services to new employer obligations

The employer support centres should make their early intervention services accessible to all employers at no charge. In exchange, this offer might be linked with stronger co-finance regulations for employers who do not use early intervention services, by obliging them to pay the potential sick-leave costs for these employees for a prolonged period, *e.g.* for the first six months.

Such regulation would require that employer support centres are perceived as highly competent by employers regarding their ability to find

solutions. The centres would be obliged to build up both an evidence base and an experience base in order to define effective and targeted intervention processes. This requires ongoing scientific evaluations, which should be carried out together with the specialist mental health services. Finally, in order to create a continuous and co-ordinated support to employees with a mental health-related work problem, advisors of the centres should continue to follow the employee in case of a prolonged need for support.

Summary and conclusions

With its traditional work-oriented approach, Norway has developed a broad range of vocational rehabilitation services which support an increasing number of clients. While on the decline in the past decade, education and training measures are still the most frequent measures for clients with mental disorders, although they are rarely used for low-educated clients but rather for re-education of people with higher education. Furthermore, education measures lead to a long period of absence from the labour market und yield only modest results in terms of competitive employment. The same is true for measures in sheltered workshops. For some years now, the NAV offices have provided qualification programmes, mainly for younger jobless people with low education, complex social needs and without a confirmed diagnosis. The first results seem promising, and there might be additional potential by inserting a systematic interdisciplinary assessment into these programmes which focuses on the mental health status of the client. Supported employment measures are used more frequently nowadays. However, it is surprising that such low recourse is being made to wage subsidies to employers, in view of their known effectiveness.

The one-stop-shop nature of the NAV offices and their involvement from sickness absence till disability benefit assessment offer a unique chance to steer labour market reintegration. However, there is a lack of evidence-based and diagnosis-specific concepts, as well as of criteria for various measures and differentiated rehabilitative programme packages. To reduce the very high dropout rates in vocational rehabilitation, the sanctions which exist on paper should be applied in practice.

There is gap between general preventive and rehabilitative measures, with nobody responsible for early intervention to assist employees with mental health problems. Employees who are at risk of dropping out of the labour market but are still at work are often not reached. There is already a structure in place which could help fill this gap, namely NAV's Employer Support Centres. To enable these centres to be more active for employees would require these centres to become multidisciplinary and not only counsel employers but also offer individual follow up to the employees concerned.

Recommendations

- Decrease further the provision of re-education and long-lasting training programmes in favour of the provision of relevant wage subsidies to employers, in order to support job-retention and re-integration.
- Decrease the number of places in sheltered workshops in favour of supported employment programmes. Seek ways to provide incentives to municipalities to promote such a reorientation in supports.
- Insert an interdisciplinary assessment and rehabilitation planning into the Qualification Programme for youth without a confirmed diagnosis in order to enhance its effectiveness.
- Develop criteria for the use of different rehabilitative measures, and define different rehabilitative programme packages for different target groups (*e.g.* different types of mental illness).
- Systematically implement the existing sanctions for non-compliance with vocational rehabilitation measures.
- Turn the focus from re-integration to early intervention in mental health-related workplace problems by expanding the existing Employer Support Centres into a powerful support structure.
- Develop interdisciplinary teams in the Employer Support Centres which should include mental health specialists. Oblige them to develop evidence-based interventions on the basis of inter-sectoral research.

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Chapter 5

Involving mental health care in Norway in employment issues

This chapter describes some key parameters of the inpatient and outpatient mental health care system in Norway with respect to consequences of the employment status of the patients. Possible ways to overcome the fragmentation between mental health care, rehabilitation and the disability benefit system are discussed. The chapter pays particular attention to the collaboration between the Labour and Welfare Administration, the District Psychiatric Centres, and the physicians in private practice. Finally, the importance and the availability of inter-sectoral data as well as the development of employment-related quality indicators and evidence-based steering mechanisms in the mental health system are discussed.

Shortcomings of the mental health care system

Modernising a formerly insufficient mental health care system

Currently, psychiatric services are making up their former backlog, concentrating on the development of a decentralised and competent mental health care system, and on the reduction of the former hospital-based system. Both the restructuring and the general expansion of the mental health care system in Norway have been a reaction to a White Paper published by the government in 1997, identifying severe deficiencies of mental health care, *e.g.* lack of inpatient resources resulting in too-high barriers for admission; general lack of competent services; long treatment delays; too early and unplanned hospital discharges; and a lack of aftercare and follow up after discharge (Pedersen and Kolstad, 2009). Mental health care was judged to be the weakest part of the Norwegian health care system (see Box 5.1 for information on the general health care system in Norway).

Box 5.1. **Health care in Norway and the role of the GP**

According to the Act on Specialist Health Care, the Act on Mental Health Care, the Act on Municipal Health Care and the National Insurance Scheme, all insured persons are granted free treatment, including medication. This applies to both inpatient and outpatient care. The patient has to pay a share of outpatient treatment costs, which amount to NOK 136 for each consultation with a general practitioner, and NOK 307 for a specialist consultation in 2011 – up to an annual ceiling of NOK 1 880 in 2011. Once this ceiling has been reached, treatment and benefits are free for the rest of the year. Inpatient treatment is free of charge.

The provision of health services is highly decentralised with most health services provided in the municipalities. According to the Municipal Health Services Act, all insured persons have the right to treatment in the municipality where they are living. Local authorities in each municipality are responsible for primary care services, which include general medical services, first-aid medical services, long term care, home care and nursing homes, and also primary mental health care. Since 2001, the Regular Practitioner Scheme which reinforced the gate-keeping role of the general practitioners (GP) foresees that all residents are entitled to be treated by a GP within their municipality who has entered into such a scheme with the local authorities. Inhabitants can choose a GP and may change him twice a year. Moreover, they are free to choose a GP in another municipality. Most GPs have a contract with the municipality and are reimbursed by the municipality within this scheme. This fixed income accounts for around 30% of the income of the GPs participating in the scheme, while the other 70% of income stems from reimbursement by NAV and from patient co-payments. Ninety-nine percent of the population is registered with a GP.

The length of hospitalisation has fallen significantly

The evaluation of mental health care in Norway criticised that inpatients were discharged too early from mental hospitals and lacked an adequate aftercare plan. However, the average length of hospitalisation with a mental illness was high ten years ago and fell drastically since – from 48 days in 2002 to 24 days in 2011 – to a level more comparable to that observed in other OECD countries (Figure 5.1, Panel A). The duration is much shorter for people with a mental illness treated in a somatic hospital. The shorter average hospital stay in Norway compared to ten years ago, however, does not make the development of a sound discharge plan any less important. Good aftercare plans and a high-quality community care system are necessary conditions for hospital stays to be beneficial for the patient (Capdevielle and Ritchie, 2008; Bruffaerts *et al.*, 2004).

The high relapse rates suggest that these conditions are not fully met in Norway. Rates of unplanned re-admissions are among the highest in a subset of OECD countries (Figure 5.1, Panel B), at least for most mental health conditions. For example, around 30% of all discharged in-patients with a schizophrenia diagnosis are re-admitted to the same hospital within 30 days, with similar findings for other diagnostic groups.

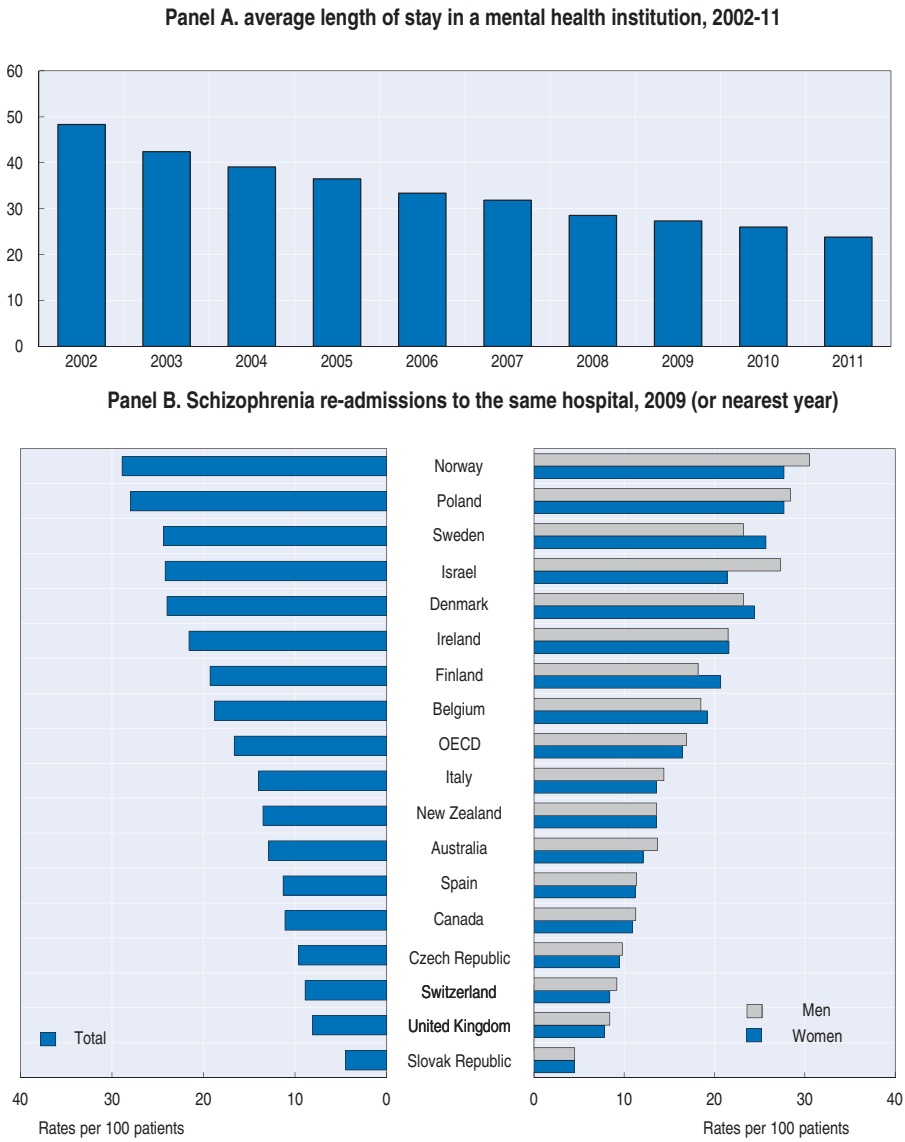
Specialised psychiatric services should support primary care

Specialist ("secondary") mental health care in Norway is based on three pillars: *i)* psychiatric inpatient care with highly specialised services on a centralised level; *ii)* District Psychiatric Centres with less specialised services on a decentralised level; and *iii)* psychiatrists and psychologists in private practice. In addition, there are primary health care services in the municipalities, comprising general practitioners, nurses and psychologists. The development of the District Psychiatric Centres has been a central component in establishing better mental health care. Today, around 80 of these centres provide almost the whole spectrum of psychiatric services, including an explicit support function for staff in primary care services.

The collaboration between municipal-based primary health care and specialist mental health care is in need of improvement. General practitioners (GPs) criticise that there are not enough capacities (*i.e.* psychiatrists and psychologists) in secondary mental health care, especially in rural areas, limiting the possibilities of adequate referrals (Mykletun *et al.*, 2010). In view of the relatively high density of psychiatrists in Norway (Figure 5.2), this problem does not seem to be explained by a lack of resources. GPs also criticise that psychiatrists and

psychologists treat a highly selective patient population for too long, leaving limited resources for others, and they see a lack of co-operation, information and knowledge transfer from the specialists' side.

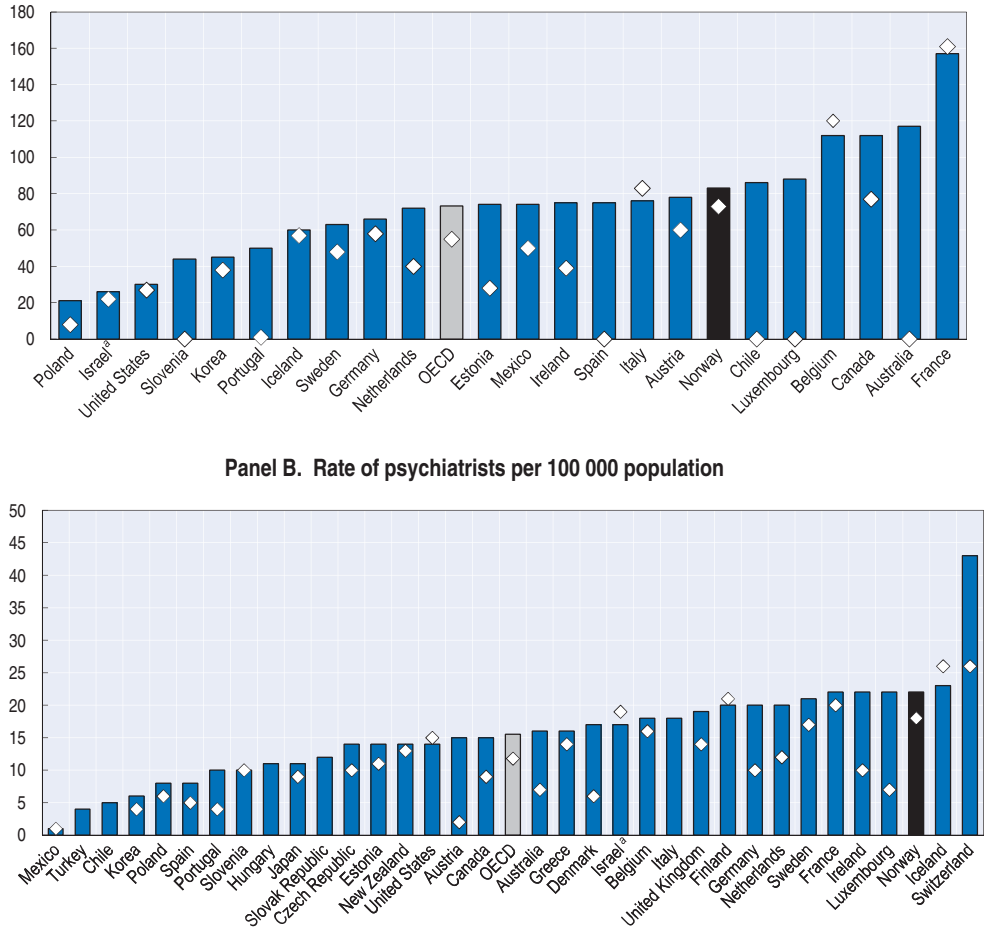
Figure 5.1. **Hospitalisations are becoming shorter, but readmissions remain frequent**



Source: Panel A: Statistics Norway (2002-10), Norwegian Patient Register (2011) and Panel B: OECD Health Care Quality Indicators Data 2011.

Figure 5.2. **More GPs and psychiatrists in Norway than in most other countries**

Density of general practitioners and psychiatrists in OECD countries per 100 000 people, earliest and latest years available



Note: The OECD average is an unweighted average.

a. Information on data for Israel: http://dx.doi.org/10.1787/888932315602.

Source: OECD Health Care Quality Indicators Data 2011.

Integrating mental health and employment services

Integration of health care and rehabilitation goes beyond co-ordination

Fragmentation between mental health and employment services goes a long way in explaining disappointing results in retaining people with mental health problems in work (OECD, 2012). There are different reasons for this fragmentation, including a narrow understanding of treatment reducing the focus to illness symptoms and underestimating the positive effects of work for helping to hasten the recovery from mental ill-health. NAV professionals, for example, do not perceive the employment situation an important issue in medical treatment, and, more generally, a priority in health services. Another barrier lies in the lack of knowledge of physicians, including psychiatrists, of how to effectively intervene in working problems, about how to deal with confidentiality issues, *e.g.* in the case of workplace conflicts.

Although psychiatric treatment is usually a necessary condition for effective vocational interventions, it is not a sufficient condition. Effective vocational measures for people with mental disorders require joint actions by physicians and rehabilitation specialists. Integration of mental health care and rehabilitation would not only mean better co-ordination, but rather to develop joint strategies and concepts on how to intervene, collaborate and communicate in mental health-related work problems, including early intervention, vocational rehabilitation, sickness certification and work-capacity examination. Although a strong connection and communication between the workplace and the health care system is an essential and cost-effective factor for job retention and labour market integration (Pomaki *et al.*, 2012), service integration is rare.

Reinforcing existing action plans with structural measures

In a rather pioneering work involving the Health Ministry and the Labour Ministry, Norway has taken up this issue by elaborating a national strategic plan for work and mental health explicitly in order to build a bridge between NAV and the healthcare sector. The plan has outlined important policy directions and initiated several promising pilot projects to improve collaboration, user involvement, service effectiveness, competence building and research. It has yet to be seen how effective these measures are in terms of systematically reducing the exclusion of people with a mental disorder from the labour market.

A specific problem in Norway lies in the fact that the mental health care system itself is *fragmented*, with general health care services on the municipal level, specialised in and outpatient services on the district level,

and highly specialised inpatient care on the county level. There are substantial problems of service integration already within mental health care, resulting in a lack of care co-ordination as well as specialist support from the municipal health care. Moreover, there are still insufficient numbers of psychiatrists and psychologists in general health care services in many municipalities while private psychiatrists seemingly treat a highly selective population, both leading to longer waiting times for treatment, especially for people with milder but disabling mental disorders. Thus, in order to improve cross-sectoral service integration, structural measures are needed, which may reach beyond the strategic plan.

Integrating general practitioners and specialists into NAV offices

One possibility would be to merge parts of primary care services and the NAV offices in the municipalities into services for labour, welfare and health care, in order to offer not only social services but also health care under the same roof. This would, for structural reasons, ensure a new and more holistic perspective on the needs and potential of clients, and thereby help to develop effective and integrated rehabilitation and treatment procedures. Possibly, it might be useful to start such merging with GPs.

An important barrier to such a solution lies in the structure of health care services which are mainly provided in private practices. Notwithstanding, it might be feasible to partly integrate GPs or group practices into the NAV structure, analogous to the current practice of municipalities having agreements with local GPs. Thus, the treatment situation of GPs working within the NAV offices would remain the same for the patients but with the possibility to offer them effective integrated treatment in the case of work problems. An integration of some GPs into NAV, which might be part-time for them, enabling them to maintain their self-employed status, might also enhance the status of the insurance physicians in NAV. Initiatives to bring physicians into the NAV offices should also involve some specialists like psychiatrists in order to treat effectively these NAV clients with mental ill-health.

Expanding the medical services in NAV

Another possibility would be to substantially increase the already existing medical workforce in the NAV offices and to give these new medical NAV units the responsibility for the medical assessment of all clients. This would also allow for the development of multidisciplinary work within NAV, for example in rehabilitation planning for clients together with the vocational rehabilitation specialist. NAV would have the possibility not only to review external medical examinations, but to systematically assess more or less all cases (where it is necessary) with respect to sick leave and

disability. In Switzerland, for example, the federal insurance office has built up regional medical services for the assessment of the work capacity of all disability insurance claimants, as well as for the reassessment of all entitlements. This has contributed to the steep decline in the incidence of disability benefit claims in Switzerland after 2003.

However, such a solution may well have some downsides, *e.g.* potential conflicts or a polarisation between the NAV doctors and the treating physicians. On the other side, there is also a potential for collaboration because many treating physicians, against the background of perceived role conflicts, would feel relieved not to be responsible any longer for sickness certification and disability examination.

Integrating NAV professionals into district psychiatric centres

Conversely, it might be useful to integrate professionals from NAV, as well as specialists from vocational rehabilitation enterprises into the district psychiatric centres. This would respond to the very high share of psychiatric patients with work problems, on sick leave or at risk of getting on sick leave, or unemployed or permanently excluded. The integration of NAV personnel into the specialised mental health centres would put them in an important strategic position because the centres are not only responsible for treatment but also for supporting the primary care services. Integrating more employment-related knowledge into the specialised psychiatric centres might have additional effects on primary care services.

Summing up, there are three possibilities to increase the integration of medical and rehabilitative knowledge in NAV: a structural integration of local GPs into NAV offices; the expansion of NAV's medical services; and a closer and more systematic collaboration of NAV with local GPs and regional psychiatric services. Each solution has its pros and cons. Building up the own medical structure is effective but costly, and might cause conflicts. A structural integration of local physicians into NAV offices might have a huge potential but is complex and might be contrary to the wishes of the GPs. Thus, a systematic collaboration between GPs, regional psychiatric centres and NAV might be a more realistic solution. In this case, collaboration as well as rights and duties should be regulated in detail to ensure a better integration of knowledge and concepts.

Developing inter-sectoral data

In order to improve the outcomes of initiatives and services for an increased retention and inclusion of people with mental health problems in the labour market, the existing databases and indicators in several areas should be expanded. Although the Norwegian administrative registry data are very rich

and offer a lot of research possibilities, these data do not fully compensate for the lack of data in many fields of interest with respect to mental health and work. There may be several possible reasons why such data are lacking. First, the link between mental health, employment and disability is a relatively new issue; second, it is an inter-sectoral issue, concerning several life domains and service sectors; and third, mental health data raise confidentiality concerns. Box 5.2 summarises some of the main data issues, with some recommendations on how to move forward in this area.

Box 5.2. **Data limitations in Norway and possible ways ahead**

A basic problem in policymaking and steering and organising of services is the lack of data connecting mental health status and vocational as well as social functioning. There are no data available about the mental health condition and the treatment situation of the majority of people with workplace problems being present at work, or, conversely, about work-status and work-functioning of people in professional treatment. To give some practical examples, it is not known how many people leaving upper secondary education without a diploma have mental health problems or how many psychiatric patients return to work or lose their job during treatment. Without such routine data, it remains difficult to improve the inter-sectoral collaboration, and to develop further existing initiatives as, *e.g.* the national strategic plan for work and mental health.

On the one hand, there is a lack of descriptive data, which would give more detailed information about the mental health-related functioning of pupils, employees, patients, and NAV clients. The development and the implementation of such epidemiological data in the different sectors might enhance the awareness of the mental health care sector regarding the significance of employment and of various public sectors regarding the significance of mental health problems. Moreover, a clearer picture of the people in education, work, or different health care settings who are at risk of exclusion or who are excluded already would help to formulate more precise criteria for intervention.

The other lack of data concerns the professional processes and the outcomes of services. Apart from NAV data on sickness absence procedures, it is not clear what activities health services or private psychiatrists undertake to improve the work situation of their patients. It might be possible to give extra funds to mental health care institutions, or private psychiatrists and general practitioners, when they involve employment-related interventions in the treatment. The development of process data should be co-ordinated with the implementation of quality indicators for health, education and social services. Such quality indicators could serve as the basis for benchmarking and more quality-driven funding. With respect to mental health care, there is a lack of data about the quality and outcomes of mental health services in Norway (Ruud, 2009).

Finally, there is a lack of outcome data. *E.g.* it is unclear how many vocational measures of NAV lead to employment or how many vulnerable workers could stay employed because with support from the relevant medical professionals. It may be not so easy to develop valid outcomes, because there are often multiple factors impacting on outcomes such as “workplace retention” or “re-integration”.

Box 5.2. **Data limitations in Norway and possible ways ahead** *(cont.)*

From a strategic point of view, the definition of employment-related outcomes for people with a mental disorder and outcome-based funding of services would be needed to overcome the existing barriers, *e.g.* the silo-thinking of different service sectors or the still widespread reluctance to put mental health problems on the agenda. Outcome-based funding of both services and municipal tasks would enable the authorities to steer their services to a higher degree.

Improving the database

- Make existing inter-sectoral data more accessible for routine analysis.
- Develop statistical routine data for GP practice and private practices of psychiatrists and psychologists including mental health and work status.
- Integrate mental health items into the school statistics.
- Develop a routine screening tool concerning employees' mental health which can be applied by the occupational health services.
- Integrate work-related items into the routine statistics of mental health care institutions for adults, and school-related items into statistics of the institutions for child psychiatric care.
- Expand process data and develop routine outcome data in NAV in order to support the development of an outcome-based culture
- Develop process data concerning mental health and work for health care, education and social services.
- Develop employment-related quality indicators for mental health care.
- Run pilot projects about the feasibility of outcome-based funding of mental health care services.

Implementing work-related quality indicators in psychiatric institutions

The integration of employment specialists in mental health care services has the potential to change the culture of psychiatric treatments by emphasizing the social and work needs of patients. Without corresponding measures, however, the position of employment specialists risks to remain marginal. To implement a serious work focus in treatment, some obligatory processes should be installed and monitored. Employment-related processes may be elaborated and used as part of the quality indicators of the psychiatric institutions, *e.g.* a mandatory screening of the work situation of all working-age patients within the first days after admission; preparing a

precise psychiatric assessment of the work capacity and the necessary rehabilitative steps in collaboration with a NAV officer; or initiating and participating in meetings at the workplace.

Because there are currently no work-related outcome criteria available, the quality indicators may, in a first step, comprise processes which are monitored and compared to other similar psychiatric services. A quality indicator that might be used very easily is the work status at discharge compared with the work status at admission. Although there are numerous reasons why patients may be unemployed when they are discharged from treatment, the yearly average may give a picture about the work focus of an institution. Such quality indicators should take into account the type of the institution, be it an inpatient facility or an outpatient facility. Inpatient treatment in Norway has become very short hence there is not much time to intervene in the working situation of a patient. However, a screening of the employment situation, a contact to the employer and a rough planning of the aftercare including the working situation should be possible. For outpatient facilities, *e.g.* the district psychiatric centres, the quality indicators should be more demanding because patients usually are treated in these institutions over an extended period. Generally, to increase the effects of such instruments, they should also have effects on the funding and staffing of the institutions.

Work-related screening in general practice

While it should be feasible to implement work-related processes into routine work in psychiatric institutions, the situation of GPs looks somewhat different. GPs are already more and more involved in the sickness absence process. This may be a good starting position to moderately expand their duties. Because GPs treat the majority of all people with mental health problems, often over long periods, they would have a unique potential for early detection of mental health-related work problems before patients are sick listed.

Physicians do not often ask patients about either their work situation or mental health problems. While work problems due to somatic diseases are normally revealed to doctors by the patients, this is often not the case in mental health-related problems. In Norway, there is seemingly still a prominent tendency to somatic labelling of mental disorders (Mykletun *et al.*, 2006). Thus, it might be useful to develop a short and simple mandatory screening tool for all working-age patients, consisting of a few questions about mental health and work. To minimise the time and effort needed, the tool should only comprise a few evidence-based questions. Moreover, a process should be developed describing what actions GPs should take when relevant mental health-related work problems are

identified. These actions should be described very clearly. Problem-specific measures might include the referral to a psychiatrist in case of work problems due to medically unexplained pain syndromes, or the referral to NAV in case of more complex needs, or the contacting of the employer in acute situations, including workplace conflicts or an acute risk of beginning sickness absence – provided the patient has given consent to this contract.

In view of the pervasive stigma of mental disorders and the fears of employees to lose their job, the consent of patients to disclose their mental health problem cannot be taken as a given. However, in view of the frequent lack of understanding of employees with mental health problems in the workplace, patients may be relieved when physicians would act more often in their place. Therefore, GPs and psychiatrists should be trained to discuss this issue with the patient and to explain the pros and cons of disclosure to the employer. The decision about disclosure is complex because disclosure can be both harmful (increasing the stigma) and helpful (enabling the implementation of changes in the workplace to meet the specific needs of the person).

Reducing waiting times for specialised treatment

While Norway has an extended net of general and specialists doctors, there are too few specialists working in the municipalities. This results partly in very long waiting times for specialised treatment (up to several months), particularly for people with more moderate mental disorders. Norway has already taken steps to increase the number of psychiatric centres and specialists working in municipalities, in both adult and child and adolescent mental health care. However, challenges remain, above all in rural regions. On the other hand there is some evidence that specialists in private practice treat a selective, highly educated clientele. As a result, two of three patient groups seem well served: people with the most severe mental disorders and those with a good social background more generally. The third and largest group, people with moderate mental disorders and some social as well as working problems, does not have easy and rapid access to psychiatric treatment.

It is understandable that people with more severe mental health conditions are treated with priority. However, when it comes to work problems, it is not efficient to put employees with moderate mental illnesses on a waiting list because, first, moderate disorders may be very disabling, causing the main societal burden through presenteeism and labour market exclusion and, second, moderate problems may develop into severe ones. In order to reinforce early intervention, people with mental health-related work problems should be able to see a specialist within one month after first contact. Solutions should be sought to broaden access to psychiatrist or

psychologist treatment. Currently a very large number of psychiatrists work in the highly specialised psychiatric clinics.

One possibility might be to transfer more personnel resources into the municipalities, *e.g.* by supporting psychiatrists and psychologists to open practices and the development of multidisciplinary group practices in the municipalities. Another possibility to enhance access to treatment might be through regulations for private specialist practices according to which only a certain share of patients can be in high-frequent long-term psychotherapies and other another share of treatment places has to be reserved for patients with mental disorders and working problems. It might also be possible to encourage psychologists to work together with GPs in group practices, combining talking therapies by the psychologist with medication by the physician. England provides a promising example of the potential benefits from substantially improving access to talking therapies. Within the Improving Access to Psychological Therapies (IAPT) programme of the National Health Service, between 2008 and 2011, 3 600 new psychologists were trained to offer evidence-based treatment and another 2 400 will be trained until 2014. These therapies have a special focus on employment of the patient and first outcomes are promising. The employment rate of patients with depressive and anxiety disorders has increased by 5% (Clark, 2011).

With the so-called "centres for work coping", a similar structure has been created in Norway. These centres offer vocational rehabilitation for people suffering from common mental disorders still at work, on sick leave or inactive. These services are currently established in six of the 19 counties. The service consists of a combination of cognitive behavioural therapy and employment specialist service, and can include up to 15 sessions. How to cope with working problems is the main issue in both therapy and rehabilitation. The employment specialist is supposed to have not only a counselling role but also to actively contact the employer. There is an intense collaboration between the therapist (employed by NAV) and the employment specialist. Up to now, about half of the clients (around 1 000) are on sick leave, 25% are at work, and 25% are unemployed. Although reliable results as to the effectiveness of this project have yet to be proven, the concept of these centres is very promising because they fully integrate an employment focus in treatment with a mental health focus in employment supports.

Summary and conclusions

Psychiatric treatment is a necessary but not sufficient condition to ensure job retention and integration of people with a mental disorder. In

addition, a conceptual integration of health care and rehabilitation services is needed. Despite the pioneering strategic plan for work and mental health, service fragmentation within the health sector and between health care and other sectors is still substantial. First, there is a lack of integration of mental health care and rehabilitation services and of primary and secondary mental health care. Above all, the important strategic position of the District Psychiatric Centres is not used for employment issues. Second, there is lesser access to specialist treatment for the large group of people with moderate mental health and work problems, with long waiting times. This is partly caused by a concentration of mental health specialists in inpatient psychiatric wards and by a high share of patients in high-frequency long-term treatment in private practice.

The fragmentation of services and concepts often results in a narrow understanding of treatment which misses key working problems of the patients and neglects illness-intrinsic characteristics in work-related supports on the other. Up to now, no quality indicators are used in mental health care which would focus on the working situation of the patients. This is especially true in general practice which has a unique potential for early detection of mental health-related work problems. However, GPs often overlook mental disorders and they are not trained to intervene in workplace problems.

Recommendations

- Develop a systematic collaboration between NAV offices, GPs and District Psychiatric Centres to enhance conceptual integration and allocate contact persons of the NAV to liaise with GPs.
- Install vocational rehabilitation professionals from the NAV offices in the District Psychiatric Centres to enhance rehabilitation know-how.
- Establish employment-related issues as a core competence in the District Psychiatric Centres.
- Partly integrate local GPs into the NAV offices.
- Develop quality indicators for institutional mental health care and implement employment as an important outcome for treatment.
- Improve receptiveness of psychiatric practices by implementing financial incentives to rapidly treat patients with acute work problems.
- Develop a training curriculum for the further education of GPs focusing on mental health-related interventions in the workplace.

- Develop a screening tool for GPs to detect mental health-related work problems.
- Improve vertical integration of the municipal, regional and centralised inpatient health care services for patients with mental disorders.
- Train physicians on how to deal with patients, who do not want to disclose their mental health problem to their employers.
- Start a research agenda focusing on employment issues in treatment.

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Chapter 6

Following up in the school-to-work transition in Norway

This chapter provides data about mental disorder prevalence, disability beneficiary caseloads and non-completion of upper secondary education in youth. It shows some diagnosis-related trends in the incidence of disability benefits in youth and discusses the balance between universal prevention measures on the one hand and targeted individual interventions at school on the other. Recommendations focus on possible ways to secure the transition from school to work and on the collaboration between the pedagogical school services and the mental health care system.

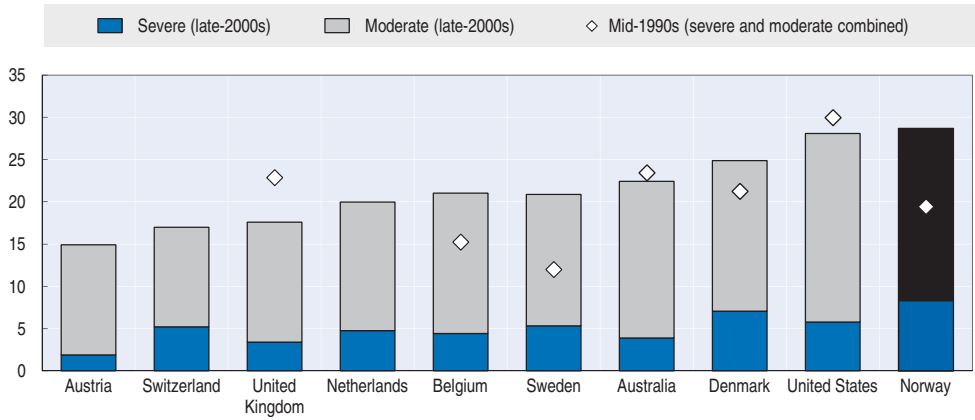
Discontinued education multiplies the problems

Psychiatric disabilities normally start during education

Mental disorders have a very early onset with a median age of 14 years, with anxiety and personality disorders beginning on average at the age of 11 years (OECD, 2012). This explains why the prevalence of mental disorders is even higher among youth than for the rest of the population (Figure 6.1). The rate of people aged 15-24 years suffering from a mental health condition in Norway is almost 30%, which is high compared with other countries. The share within this group who have a severe condition is also relatively high, and there has been a considerable increase of youth with a self-reported mental health problem in the past 15 years in Norway, just like in the other Nordic countries.

Figure 6.1. **Around one in four young people have a mental disorder**

People aged 15-24 with a mental disorder as a percentage of the total youth population, late-2000s and mid-1990s



Source: OECD calculations based on national health surveys (NHS) or interview (HIS) surveys. Australia: NHS 2001 and 2007/08; Austria: HIS 2006/07; Belgium: HIS 1997 and 2008; Denmark: NHIS 1994 and 2005; Netherlands: POLS Health Survey 20001/03 and 2007/09; Norway: Level of Living and Health Survey 1998 and 2008; Sweden: Survey on Living Conditions 1994/95 and 2009/10; Switzerland: Health Survey 2002 and 2007; United Kingdom: Adult Psychiatric Morbidity Survey 2007; United States: NHIS 1997 and 2008.

The early onset of mental ill-health hits children, adolescents and young adults in a vulnerable period of life, when they are in the middle of their psychological, social and educational development, leading not only to reduced well-being, but also to problems with their peer group, behavioural problems, and reduced performance in school. If not adequately treated, these problems may have further negative consequences such as dropout

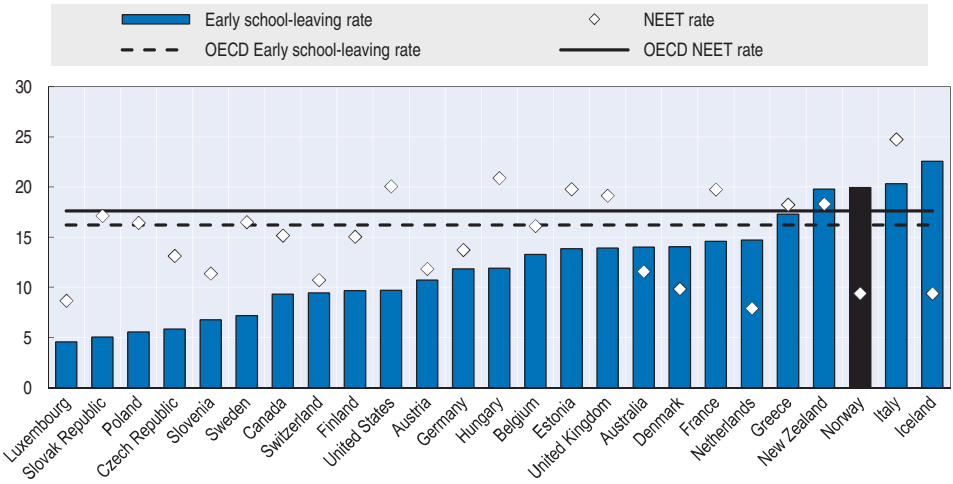
from school or apprenticeship, transition problems and finally, an uncertain integration into the labour market. Moreover, the development of mental disorders is not evenly distributed in the population, but often combined with a disadvantaged socioeconomic status and a lower educational attainment of the parents, causing a lack of individual resources to cope with later working problems.

School drop-out reduces the labour market prospects

Because psychiatric disability normally has its origin very early, it is crucial to identify youth at risk and support them in continuing education. In Norway, the rate of youth who leave school prematurely is high with around every fifth 20-24 year old not being in education and not having an upper secondary degree (Figure 6.2). Female students show rates comparable to other countries, but the share of young men without upper secondary degree and having left the school system is much higher. While there are many early school leavers in Norway, the percentage of young people neither employed nor in education (NEET) is significantly below the OECD average. In other words, many early school leavers are working in Norway.

Figure 6.2. **Early school-leaving is frequent in Norway partly because of a high drop-out rate from vocational education**

Proportion of youth aged 20-24 (i) not in education and without upper-secondary diploma (early school leavers) and (ii) not employed and not in education (NEET), 2009



Note: OECD total includes all 34 member countries.

Source: OECD Education Database.

A range of youth support services, but dropout remains prevalent

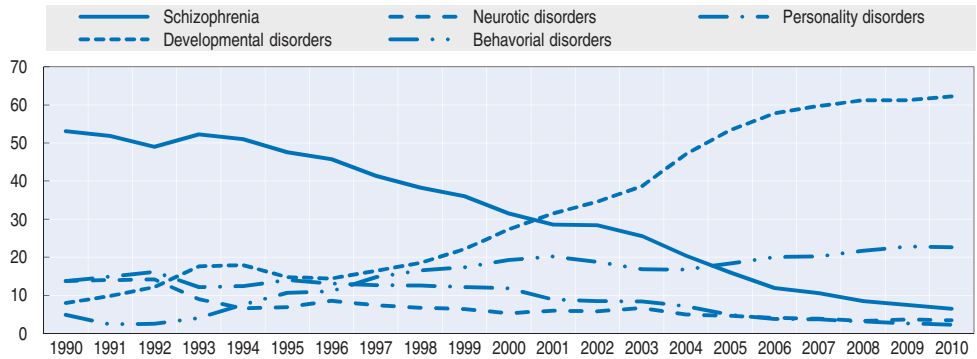
Dropout is very prevalent in Norwegian schools with dropout rates from vocational apprenticeship-type education reaching 45%. This is striking because Norway invests significant resources in building up good school environments, and there has been a rather high awareness of the importance of a productive learning environment that promotes well-being. There are a range of services in place on a municipal level to support students with psychosocial problems as well as specialist services on a county level which have a support function to the municipalities, but there is a lack of responsibility to follow up on students with mental health problems in a sustainable way. NAV has introduced a new project called "New Possibilities" to follow up premature school leavers in a more assertive way. However, the first aim should be to prevent school dropout by identifying youth with mental health problems earlier, and supporting them in the long-term in a more co-ordinated way. In this regard, the support systems for youth face the same problems as those for adults.

Change of trend in the disability causes in youth

Disability benefits in the youngest age group have increased in the past 15 years in Norway, similar to other countries. With respect to the type of mental health condition, data show a clear change of trend. Fifteen years ago the predominant mental disorder leading to disability in youth was schizophrenia (Figure 6.3).

Figure 6.3. **The composition of mental disorders leading to a disability benefit claim among young people is changing**

Share of different mental disorders in all recipients of a disability benefit aged 18-24 with a mental disorder, 1990-2010



Source: OECD questionnaire on mental health.

This has changed altogether. The "new" mental disorders leading to disability in young age are behavioural and emotional childhood disorders, mostly ADHD: their share has increased from 25% to 80%. It is unlikely that the support systems, which have traditionally focused schizophrenic disorders, have kept up with this development.

Better school-to-work transition for youth with mental ill-health

There is a strong association between ill-health in youth, school dropout and social insurance benefit recipiency in adulthood. Around 25% of high school non-completers receive a medical or non-medical long-term benefit at the age of 26 (De Ridder *et al.*, 2012), compared with 7% of those who completed secondary education. Thus, low education and a poor mental health status in adolescence impose a high risk for not succeeding in the transition to the labour market. On the other hand, Norwegian studies show that low education is a risk factor for developing a mental disorder (Bjelland *et al.*, 2008). Non-completion of secondary education affects substantial numbers of young people in Norway which has the third-highest rate of early school leavers in the OECD. Therefore, non-completion should be tackled effectively and early. In order to improve the transition of vulnerable young people with mental health problems to the labour market, support measures are needed in different areas; *i)* measures for early intervention and dropout prevention in schools and apprenticeships; *ii)* measures to follow up school dropouts, and *iii)* measures to secure the transition into employment.

Balancing universal health promotion and targeted interventions

Schools are an important place for early intervention because adolescents spend a lot of time in general or vocational education and training during an important period of their psychological development. Moreover, teachers have intensive contacts with pupils, and may perceive psychological problems at an early stage. Thus, schools provide an easy-access environment for identification of and intervention with mental health problems (Weare and Nind, 2011). However, both the high prevalence of mental health conditions in youth and the stigma attached to mental disorders make it difficult to intervene. About 20% of female and 9% of male pupils (16-19 years) report definite to severe emotional problems (Andersson *et al.*, 2010). In a representative Norwegian study with adolescents aged 14-16 years, almost 25% had lifetime depressive disorders (Sund *et al.*, 2011). In primary schools (8-10 years), a prevalence of 7% was found for psychiatric disorders, often anxiety disorders, behavioural disorders and ADHD (Heiervang *et al.*, 2007). Although not all pupils with

mental health problems need professional treatment, it is estimated that up to 10% of the youth in Norway have mental health conditions requiring treatment.

With respect to general prevention, Norway has a range of school-based programmes in place. Most of these programmes aim to improve the learning environment, school quality ("Better learning environment") and school performance, because dropout in secondary education is seen as a result of poor learning in earlier school years. "New possibilities" recently introduced by the Ministry of Education aims at improving the completion rate in upper secondary education from 70% to 75% by 2015. Measures include early intervention in the case of poor school results, individual follow-up through increased support in basic skills, documentation of absences, professionalisation of the career and guidance services, and more practice-oriented vocational education and training. Moreover, collaboration between the follow-up services and NAV has been improved. While there is potential to improve the transition to work for young people, there has been criticism that the screening criteria for pupils at risk are not detailed enough to start early intervention. A systematic registration of truancy might be a possibility to identify more students in need for assistance (Mounteney *et al.*, 2010).

Generally, evidence shows that general prevention programmes for mental health can be effective; however, they need to keep a balance between universal and targeted interventions (Weare and Nind, 2011). It is questionable whether such balance exists in Norway. The "Governmental strategy plan for children and adolescents mental health" for the period 2003-2008 has had a health promotion and prevention profile in order to strengthen the coping ability of youth (Adnanes and Halsteinli, 2009). However, an important target group is those youth who have already developed mental health problems and need competent services.

Other programmes within the government's strategic plan for mental health, *e.g.* "Mental Health in Schools", aim to raise the awareness of mental health conditions and available supports and confidence in the effects of treatment. A recent comparison of such an information campaign with respect to psychotic symptoms showed positive effects (Langeveld *et al.*, 2011), with trained teachers being better able to correctly identify a psychosis. Such training programmes for teachers also offer a base for intensified collaboration between the education and the mental health care systems. However, it remains uncertain whether it is effective and feasible to train teachers in identifying not only psychotic symptoms (which are quite rare), but a broad range of different mental disorders. It is also necessary to train teachers to generally be able to identify early signs of mental health problems focusing on the very prevalent disorders like social

withdrawal, interpersonal conflicts, avoidant behaviour and rapid change in school performance. It is crucial that the scope of identification is not narrowed to pupils with defiant behaviour, hyperactivity or conduct disorders, but includes less visible and less disruptive mental health problems such as anxiety and depressive disorders.

Measures to ensure school attachment and school completion should have priority. If school dropout cannot be prevented, assertive outreach measures are necessary to keep in contact with youth who left the education system. The probability of youth to return to school after having been out of the system for more than a year is very low (Raaum *et al.*, 2009). Currently, NAV has registered around 4 500 jobseekers under 20 while, according to Statistics Norway, there are 14 000 jobseekers 15-19 years old. Because the follow-up services of the municipalities lose contact with around a third of youth who left education and who are not in employment, the promising "OT/NAV-16-19" project was started, involving NAV and the municipalities' follow-up services. Students with low performance are to be monitored and all dropouts from upper secondary school will be contacted by these follow-up services. There are no data about the effectiveness of the follow-up service up to now but this project goes into the right direction. However, if the contacted youths do not respond, or if they cannot be motivated to return to school or to start integration measures with NAV, there will be no further action. Better indicators for pupils at risk and dropouts with mental disorders are needed as well as more assertive outreach in vulnerable cases and a support network *before* dropout happens.

Adolescents are mostly treated by general health care

In general, adolescents with mental health problems seldom seek professional help for their emotional problems, a problem which is also seen in Norway (Zachrisson *et al.*, 2006). Only a third of the 15-16 year-olds with the highest percentile on anxiety and depression seek treatment. Within the highest 10th percentile, the share is 24%. Moreover, of those who seek professional help for their mental health problem, only 40% are treated by a psychiatrist or a psychologist, while the majority is treated by a general practitioner. The reluctance of adolescents to seek help for a psychological problem – in contrast to seeking help for a physical problem – is a main barrier to treatment. Recent initiatives like "Mental Health in Schools", aiming to create a more open atmosphere to discuss emotional problems in schools, have the potential to tackle such barriers.

Norwegian data also show that adolescents with anxiety and depression commonly have contact with multiple service providers in a given year, mostly GPs, school health services, emergency wards and youth health clinics (Zachrisson *et al.*, 2006). Contacts with health care providers always

offer the possibility to recognise mental health problems and to refer patients to specialists. However, the many contacts with the health system do not seem to result in the recognition of mental health problems or the referral to specialised treatment. Only 3% of all health service contacts of adolescents with symptoms are contacts to psychiatrists or psychologists. Thus, under treatment in youths is partly caused by a lack of awareness on the part of non-specialised professionals and scarce specialised resources.

Moreover, under treatment seems especially severe in children and adolescents with emotional disorders, with only 13% of the 8-10 year-olds with emotional disorders being (or previously having been) in specialised mental health care (Heiervang *et al.*, 2007). This is in contrast to children with attention deficit and hyperactivity disorder (ADHD), who are very often treated by multiple services (75% have contact with specialist mental health services). That is, adolescents with noticeable behavioural problems have a high chance to be treated by multiple professionals, while the chance to get treated is low in the case of less visible mental disorders. ADHD awareness has risen substantially over the past few years; this has translated into a high treatment rate of these conditions (Kriz and Thomsen, 2009). With respect to the majority with less visible emotional problems, however, there is still a way to go.

Fifteen years ago, Norway's psychiatric services only treated around 2% of the population aged under 18 (Kriz and Thomsen, 2009). The aim of the then government was to increase the rate to 5% in 2006 and consultations per full-time therapist by 50% (Halsteinli, 2010). In 2006, the productivity of the therapists had increased and the treatment rate reached 4.6%. However, the treatment rate remains below the estimated range of 8-10% of children and adolescents in need of treatment. Moreover, in some Norwegian regions the treatment rate is still significantly lower (Kriz and Thomsen, 2009). The same is true for school health services which, depending on the municipality and due to a lack of resources, offer only restricted access to health personnel. School-based health services are not necessarily located at the school and easy access to such services is not guaranteed (in some schools, *e.g.* a nurse is available for no more than two hours per week).

There is evidence that school-based health centres can increase specialised treatment rates and health-related quality of life of pupils with mental health problems (Guo *et al.*, 2008). Moreover, they meet the needs of pupils more than office-based practices (Anderson and Lowen, 2010) if they have an integrated approach, *e.g.* collaborating closely with social services. Clinics which are located in schools are used by 50-70% of students and are the predominant place for pupils to seek help for personal and alcohol-related problems. Finally, students who are treated by school-based health

services have fewer hospitalisations and emergency visits (Anderson and Lowen, 2010). However, this requires not only an excellent collaboration between schools and health services (American Academy of Pediatrics, 2004), but also an adequate funding and accessibility which is not restricted to school hours only (*e.g.* in the case of pupils in need who are not attending school).

Taken together, a further expansion of the child and adolescent psychiatric resources would facilitate the access to specialised services. Pupils perceive the school health service as an easy-access service and express a need for more services of that kind. Beyond resources, a better access might also be possible by integrating psychiatrists and psychologists into the local school health services which are a part of the municipal general health care service. Supported by mental health specialists, school health services could offer active guidance for teachers on how to identify and handle pupils with psychological problems.

Integrated and continuous supports

Identification of vulnerable pupils and qualified treatment are necessary but not sufficient steps. Norway has a range of professional services in place, including the educational and psychological services (PPS), which should refer students with mental disorders to health services; child welfare services which assess students with drug problems; school advisors and career counsellors for vocational counselling; or the school health services as a part of the municipal health services. However, teachers do not feel supported enough by these services; many of the services are not located in the school; and none of them are in charge to follow up pupils with enduring mental health conditions.

The central services with respect to pupils with mental health conditions, the PPS and the school health services, are not obliged to co-operate – resulting in a perceived lack of collaboration. This is partly due to different approaches – with the PPS having a general pedagogical focus and the health services an individual medical approach. This results in a lack of identification of pupils with mental disorders by the PPS, many of whom need pedagogical support as well as treatment.

The lack of a systematic and integrated approach between the different services reduces the effectiveness of the supports in the long run. Supports to perform in school, complete upper secondary education, and get established in the labour market, should be conceptually and personally integrated. It should be clear to all professionals, as well as to the adolescent and their parents, what the problem is, how it should be overcome and which service is in charge for what type of support.

Measures to increase educational attachment and completion of upper secondary education should also concentrate on vocational education (apprenticeships) as for this group non-completion is especially frequent (OECD, 2008). Several actions were started to make vocational education more practice-oriented, to assure quality of apprenticeship training and to train teachers in VET. However, there are no specific actions regarding apprentices with mental health problems. While many young people who do not complete their apprenticeship will nevertheless find a job, this often does not apply to youths with mental health problems. Just as other teachers, VET teachers should get instruction on how to identify apprentices at risk, and how to get support for them. It might be effective to establish a systematic collaboration between the VET programmes, the municipal health services, NAV and employers, and to develop intervention guidelines and referral criteria.

Securing the transition to work

Comprehensive and integrated approaches for adolescent health care are crucial to get good results in staying on in school. This requires co-ordinated health, education and municipal social services (Anderson and Lowen, 2010). However, the close collaboration between these services is not sufficient to ensure a secure transition to the labour market. So far, there is no continuous support for young people with mental health problems to enter the labour market. The adolescent school and health support services should develop further the collaboration with NAV in the case of youth with identified mental health problems for early rehabilitation planning and a secure transition to employment, as is partly done in practice already.

Practical training in apprenticeships is usually the first work experience. It is very important for vulnerable apprentices to turn this into a positive experience. Employers, who compared with their counterparts in other countries receive substantial subsidies for apprenticeships, should be obliged to work closely with the support system. Reciprocally, NAV should offer job coaching during both the apprenticeship and the first months after the transition to work. Such support could be built along the conceptual lines of supported employment programmes, *i.e.* in systematic collaboration between the youth, the employer, the NAV counsellor and the treating professional.

Summary and conclusions

Low educational attainment combined with mental health problems in adolescents imposes a high risk for not succeeding in the transition to the labour market. Non-completion of secondary education is an especially prevalent problem in Norway. This is problematic because an upper

secondary diploma is viewed as a key factor for success in the Norwegian labour market. The dropout rate from apprenticeships is particularly high. Moreover, less visible mental disorders like *e.g*. depression which are more difficult to perceive are rarely detected and therefore rarely treated effectively.

Schools are an important place for identification and early intervention in mental disorders, and in dropout prevention. However, the high prevalence of mental health problems in pupils and the stigma attached to mental disorders make it difficult to intervene. Norway, so far, has given priority to promising general prevention measures aiming to improve school quality and school performance and to tackle mental health stigma. An important project to reach school dropouts has been started; however this project is not very assertive. Furthermore, there are a lot of pedagogical and psychological support services as well as school-based health services. The huge potential of these initiatives and services is not fully exploited yet due to very different approaches being taken by the pedagogical and the health care services and a lack of co-operation. Teachers do not feel adequately supported by the pedagogical and psychological services. Furthermore, access to school-based health services is often limited due to a lack of resources. Service fragmentation implies that the transition of vulnerable adolescents to the labour market is not secured, although there is a broad range of services available.

Recommendations

- Oblige the pedagogical and psychological services to systematically collaborate with the school health services and with child psychiatric services in case of pupils with mental health problems.
- Increase resources of the school-based health services to ensure easy access, further increase the number of child psychiatrists and integrate more child psychiatrists or psychologists into school health services.
- Raise the awareness about mental health problems in vocational education and train teachers how to intervene to help such youths.
- Establish a close contact between NAV offices and local employers offering apprenticeships in order to prevent dropout – in collaboration with municipal health services.

- Develop specific measures and guidelines to support employers and offer long-time follow up of apprentices with mental health problems.
- Expand the Qualification Programme explicitly to include youth with mental disorders.

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Mental Health and Work

NORWAY

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Further reading

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Mental Health and Work: Belgium (2013)
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