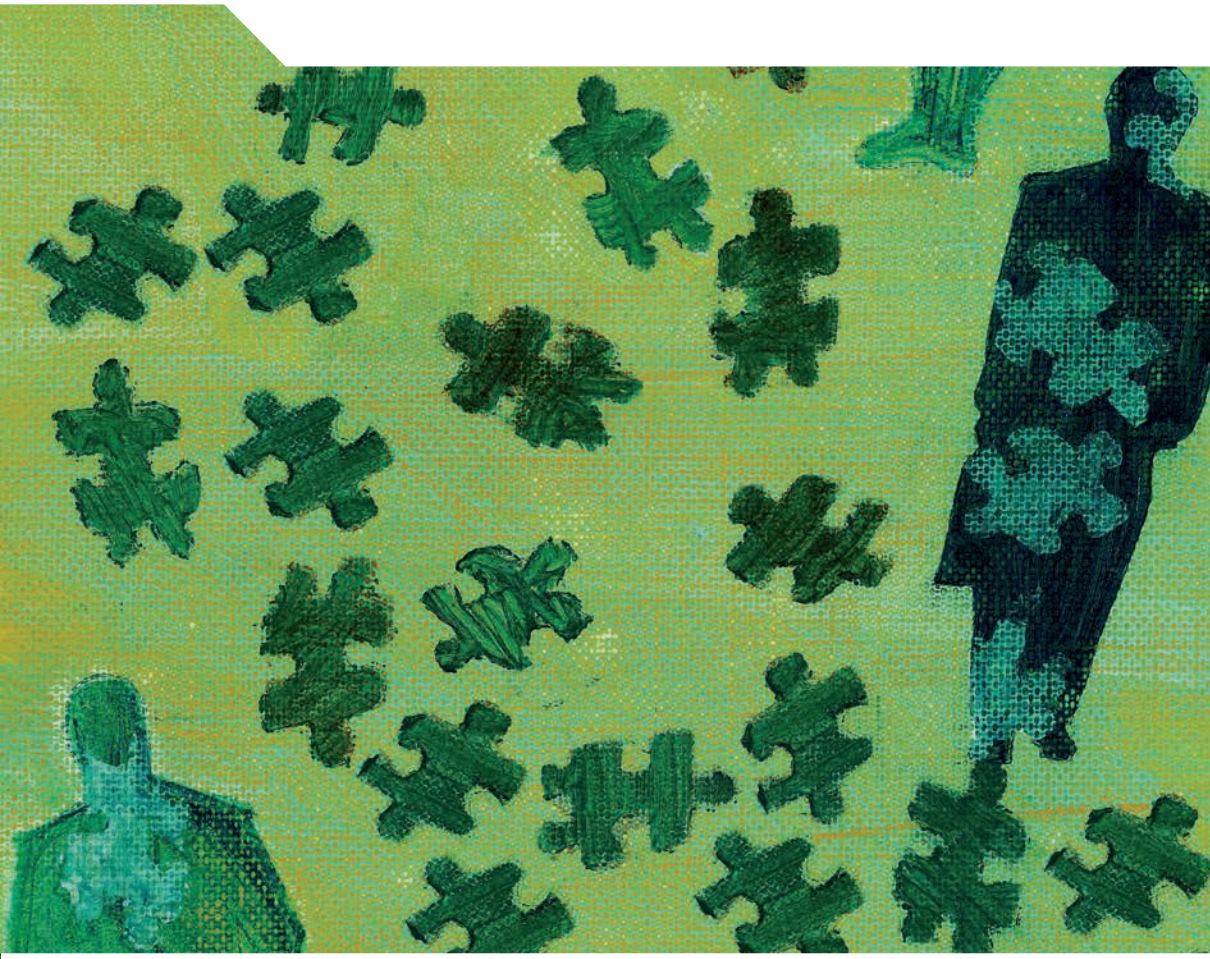
# Mental Health and Work

# SWEDEN



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# Mental Health and Work: Sweden

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**Please cite this publication as:**
OECD (2013), *Mental Health and Work: Sweden*, OECD Publishing.
*http://dx.doi.org/10.1787/9789264188730-en*

ISBN 978-92-64-18870-9 (print)
ISBN 978-92-64-18873-0 (PDF)

Series: Mental Health and Work
ISSN 2225-7977 (print)
ISSN 2225-7985 (online)

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# *Foreword*

Tackling mental ill-health of the working-age population has become 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; and avoiding long-term sickness and disability caused by a mental disorder.

A first OECD report on this subject, *Sick on the Job? Myths and Realities about Mental Health and Work*, published in January 2012, identified the main underlying policy challenges facing OECD countries by broadening the evidence base and questioning some myths around the links between mental ill-health and work. This report on Sweden is one in a series of reports looking at how these policy challenges are being tackled in selected OECD countries, covering issues such as the transition from education to employment, the workplace, the institutions providing employment services for jobseekers, the transition into permanent disability and the capacity of the health system. Other reports look at the situation in Australia, Austria, Denmark, the Netherlands, Norway, Switzerland, and the United Kingdom. Together, these nine reports aim to deepen the evidence on good mental health and work policy. Each report also contains a series of detailed country-specific policy recommendations.

Work on this review was a collaborative effort carried out jointly by the Employment Analysis and Policy Division and the Social Policy Division of the OECD Directorate for Employment, Labour and Social Affairs. The report was prepared by Shruti Singh under the supervision of Christopher Prinz. Statistical work was provided by Dana Blumin and Maxime Ladaique. Valuable comments were provided by Stefano Scarpetta and Mark Keese. The report also includes comments received from experts and various Swedish ministries and authorities, including Dr. Tony Klein MD (Uppsala), the Ministry of Health and Social Affairs, Swedish Social Insurance Inspectorate, Swedish Social Insurance Agency, Ministry of Education and the Swedish Work Environment Authority.

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# *Acronyms and abbreviations*

| | |
|---|---|
| ALMPs | Active Labour Market Programmes |
| AW | Average Wage |
| CBT | Cognitive Behavioural Therapy |
| EWCS | European Working Conditions Survey |
| EITC | Earned Income Tax Credit |
| EPL | Employment Protection Legislation |
| GPs | General Practitioners |
| IAPT | Individual Access to Psychological Therapies |
| ICD | International Classification of Diseases |
| IPS | Individual Placement and Support |
| ISF | Swedish Social Insurance Inspectorate |
| JDG | Job Development Guarantee |
| OHS | Occupational Health Services |
| NBHW | National Board of Health and Welfare |
| NEET | Not in employment nor in education or training |
| PES | Public Employment Service |
| RTW | Return to Work |
| SALAR | Swedish Association of Local Authorities and Regions |
| SAM | Systematic Working Environment Routine |
| SSIA | Social Insurance Agency |
| SHARE | Survey of Health, Ageing and Retirement in Europe |
| SSE | Small-Scale Enterprises |
| UI | Unemployment Insurance |
| ULF | Living Conditions Survey |
| ULF-Barn | Living Conditions Survey of Children |
| UM | Youth Centres |
| WEA | Working Environment Authority |

# *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. The Swedish Government has embarked on various policies and strategies that seek to combat the negative consequences of mental ill-health. Nonetheless, a number of barriers persist, including insufficient resources, lack of awareness and tools to identify and, hence, help those with a mental disorder. Above all, it is important to recognise that problems related to mental ill-health cannot be solved without strong co-ordination between policy areas and institutions. A systematic and sustained effort is required across different government departments (including, Education, Health, Social Insurance and Employment) and workplaces to improve labour market inclusion of people with a mental illness and prevent large social and economic losses incurred by the Swedish society as a whole.

The OECD recommends to Sweden to:

- Increase resources available for school health services to identify and provide support to pupils with mental health problems early on.
- Provide adequate support to early school leavers and NEET with mental health problems to promote their transition into higher education and employment.
- Reform the disability benefit scheme for those aged 19-29 who tend to access the system with a mental illness, with much greater focus on active measures to avoid an early exit from the labour market.
- Provide greater support to small employers to retain workers with mental health problems; to prevent them from moving onto sickness benefits; and to reintegrate sick employees.
- Ensure that adequate employment and health services are given to sickness benefit recipients with mental health problems at an early stage of the sickness spell to facilitate their rapid return to work.
- Develop employment-oriented mental health care and experiment with ways to integrate health and employment services.

# *Assessment and recommendations*

Mental ill-health is a fast-growing problem which costs the Swedish economy more than EUR 7 billion every year through lost productivity, social benefits and healthcare. With mental ill-health accounting for 60% of all new disability claims, it has become the leading cause of labour market exclusion among the working-age population in Sweden; and especially among young people. People with mental disorders are poorly integrated in the labour market. Many of those who are employed struggle in their jobs and those who become unemployed receive inadequate support and have poor chances of reintegrating in the labour market.

Policy makers and service providers in Sweden recognise the need to take steps to tackle mental ill-health but current action is inadequate despite the magnitude of the mental health burden. A more comprehensive effort and a long-term commitment is needed to prevent problems from arising in the first place and to respond more effectively when they do occur.

## Investing in mental health needs to start at an early age

Mental health problems often begin early in life. If left unaddressed in school and during the transition from school to employment, they can have major negative consequences in adulthood. Swedish school health services are under-resourced to help pupils in coping with behavioural and psychological problems, and waiting times to see a psychologist are too long. Recent initiatives to increase the number of psychologists and expand resources towards school health care are promising. However, it would be essential to strengthen guidelines for school social workers, nurses and psychologists on how to deal with students who encounter mental health problems.

Securing employment is an important part of the transition into adulthood and an important element of overall well-being. This is particularly important for young people who are neither in employment, nor in education or training (NEET) whose life chances are poorer than those of their peers. Among the NEET, young Swedish men are twice as likely to suffer from a mental disorder and the likelihood of young women suffering from depression or anxiety is even higher. Greater efforts are needed to identify and support this group in order to facilitate their transition from school to work.

Tackling early withdrawal from the labour market among young people is one of the key challenges facing Sweden. Currently, over a third of all new disability claims are from people in the age group 15-24. Following the reforms to the disability benefit scheme for adults, a comprehensive reform is now required for the corresponding scheme for young people under the age of 30, including an increased focus on vocational rehabilitation and active measures. Disability benefit entitlement for youth with a disability for prolonged schooling should be replaced by a study grant. Youth-friendly employment policies and measures to boost labour demand should be pursued to prevent long-term unemployment and the risk of early dependence on disability benefits.

## Managing large-scale mental health problems at the workplace

Mental disorders are the most common work-related health problem in Sweden. As an employer, understanding what causes stress and when it is likely to occur is critical in managing mental health in the workplace. The current framework under the Working Environment Act on how to identify psychological risks is potentially useful, but small enterprises struggle with implementing risk assessments. For employees underperforming at work due to psychological disorders, occupational health services should play a greater role in addressing their needs and supporting their return to work after a period of sick leave. Providing supervisors and line managers with training, on clinical and occupational aspects of mental ill-health, would improve their ability to respond confidently and in a timely fashion to employees suffering from mental disorders.

Support and incentives for employers to retain workers appear to have weakened with the latest sickness reforms. The Social Insurance Authority (SSIA) therefore needs to be watchful that the large number of persons returning to work after a long period of sickness absence does not face the same problems again due to a lack of action by the employer. Financial incentives should be readjusted if inflows into sickness benefit bounce back up in the future. It is essential that all those in contact with people on sick leave focus on achieving realistic employment goals as quickly as possible, and communicate effectively with each other where appropriate.

## Preventing labour market exclusion and benefit dependency

The substantial reduction in the number of persons on long-term sickness and disability benefits has been a major achievement of the recent reforms introduced in Sweden. That said, these reforms have yet to prove that these outcomes will be sustainable in the long-run; that they will ultimately lead to higher levels of employment; and that those who left the system will not re-enter the sickness benefit system. This is a concern particularly for those with

a mental disorder and those who have fallen sick while unemployed as the evidence suggests that these reforms have been less effective for this group.

Further action is warranted in a number of areas to meet remaining challenges. First, institutional and individual incentives need to be strengthened. Lack of hard financial incentives is a factor for weak co-operation between the SSIA and the public employment service (PES). Coupled with non-obligatory participation requirements in "contact meetings", this is likely to subvert the effects of the Rehabilitation Chain. Such a passive approach in particular is undesirable for persons with a mental disorder for whom maintaining labour market attachment in the early phase of their sickness spell could encourage a quicker move back into the labour market. Second, the SSIA needs to boost follow-up support measures to workers with mental health problems returning to their previous jobs by strengthening its links with employers and either building internal capacity for vocational rehabilitation or outsourcing services that offer combined psychological and employment support. Third, reintegration measures in co-operation with the PES need to improve for the long-term sick. At the moment, systematic support is only offered to those who have exhausted their sickness benefit entitlement (after 2.5 years of benefit payment) through the so-called Work Introduction Programme. This programme has strong features (*e.g.* it is mandatory) but at this stage it is difficult to achieve employment outcomes. Knowing that re-employment probabilities fall rapidly with the duration of sickness absence, similar PES support should be offered much earlier, with or without a corresponding cut in the maximum sickness benefit payment period

Another big challenge facing the disability system following comprehensive reform is to ensure adequate social protection. With increasingly tighter access to the disability benefit system, it is imperative that the authorities monitor and follow up rejected claimants so that they do not fall out of the social protection system completely, with an increased risk of poverty.

Policy makers also need to shift their attention to tackling mental health problems among the unemployed, in particular the long-term unemployed. Ways should be sought to identify mental health support, for example, through the use of job-profiling tools. Job-search programmes should be supplemented with counselling and motivational programmes early on to break the vicious cycle between mental ill-health and unemployment.

## Early access to integrated work-focused support and treatment

Recent initiatives to enhance co-operation between the employment and the health sector still have a long way to go to achieve the desired integrated service delivery, with common employment goals, that has the best prospect

of keeping people in work. Substantial efforts need to be made in this regard. In the short-run, the National Board of Health and Welfare should adopt a key role in endorsing employment as an integral part of the recovery process through greater dissemination of evidence on work-focussed treatment. Better financial incentives (*e.g.* outcome based funding) are needed to improve the outcomes of the Rehabilitation Guarantee through which psychological treatment is offered to recipients of sickness benefit recipients. In the long-run, both the health and the employment system could build vocational and clinical capacity respectively within their own areas of responsibility, as seen in other OECD countries *e.g.* United Kingdom. An underlying challenge for the health system is to improve the treatment gap by reinforcing mental health services in primary care. General practitioners (GPs) need adequate training in mental health so they can recognise symptoms of physical as well as mental illness and treat patients accordingly (or refer them to a specialist, if necessary).

**Summary of the main OECD recommendations for Sweden**

| Key policy challenges | Policy recommendations |
|---|---|
| 1. Improving access to mental health services in schools | • Increase mental health resources for youth, including of school health services.<br>• Implement guidelines for school nurses, school social workers and school psychologists. |
| 2. Ensuring successful transition into the labour market for NEET with mental health problems | • Consider setting up a "youth agency" or use existing Navigator Centres in order to systematically identify and connect the NEET group with necessary services.<br>• Have sufficiently resources Youth Clinics all across Sweden to provide low-threshold mental health interventions.<br>• Provide co-ordinated employment and health services to vulnerable youth through *e.g.* the Navigator centres. |
| 3. Reducing early dependency on disability benefits | • Abolish granting activity compensation for prolonged schooling; instead consider a study grant for youth with disability in special schools.<br>• Adopt a more active approach with greater focus on employment measures. |
| 4. Strengthening incentives for employers to prevent mental illness and retain sick employees | • Make longer-term sick leave more costly for the employer.<br>• Occupational health specialists should provide on-the-job coaching and continuous support for employees with mental disorders.<br>• Provide training to supervisors and managers to enable them to support employees with mental disorders. |

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

| Key policy challenges | Policy recommendations |
|---|---|
| 5. Ensuring labour market attachment and facilitating rapid return to work for sickness benefit recipients with a mental disorder | • Make PES responsible for the payment of sickness benefit of the unemployed.<br>• Introduce mandatory meetings with the PES for the long-term unemployed sick.<br>• Offer mandatory PES support to the long-term sick systematically much earlier, not only after exhaustion of the 2.5-year sickness benefit entitlement.<br>• SSIA should follow-up workers with mental disorders returning to their previous jobs. |
| 6. Addressing mental health problems among the unemployed | • Supplement job-search programmes with psychological and motivational support.<br>• Target the Job-Coach programme to those with a mild mental disorder. |
| 7. Joining-up mental health care and employment services | • Mutually integrate vocational and clinical services.<br>• National Action plan on mental health should include employment outcomes.<br>• NBHW should promote employment as a part of the treatment process.<br>• Increasing incentives to improve outcomes of the Rehabilitation Guarantee.<br>• Provide e-learning support for GPs and healthcare professionals in primary care. |

# *Chapter 1*

# Mental health and work challenges in Sweden

*This chapter discusses the current labour market performance of people with a mental disorder in terms of their employment and unemployment situation, with a view on sickness absence and reduced productivity of those working. Building on the findings in the recently published OECD report "Sick on the Job?", it highlights the key challenges ahead, such as the high share of people on different social benefits who suffer from a mental health condition. The chapter also provides a description and an assessment of the three main systems catering for people with mental illness: social protection and income support, the education system, and health care.*

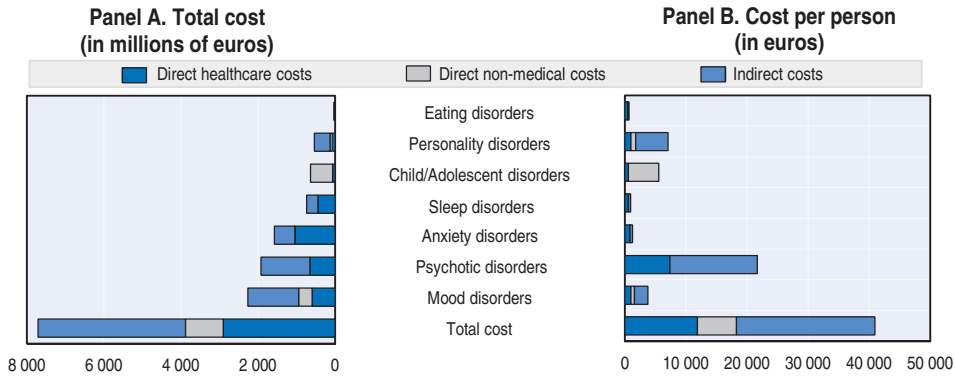
In Sweden, nearly 1 million working-age individuals suffer from a mental disorder in any given year and as many as one in two experiences a mental-health condition at some point during their lives. As a result of its high prevalence, mental ill-health presents major challenges to the functioning of the labour market, and the wider economy.

The associated economic and social costs of mental illness are clear and unequivocal. Not only does mental illness constitute a heavy burden on individuals and their families, but it also creates very significant budgetary costs and a loss of economic output. In Sweden, as in other OECD countries, mental illness is a major inhibiting factor of productivity at work, and it is responsible for a very significant loss of potential labour supply through joblessness or sickness absence (OECD, 2012).

A recent European study puts the economic costs of mental disorders in Sweden at some EUR 7.7 billion, or 2% of GDP, each year (Figure 1.1, Panel A). The direct medical cost of treating and supporting mental illness are estimated to account for 50% of the total, while a similar amount is attributable to output loss resulting from work absence and out-of-work benefits (indirect costs). Estimated costs per person are particularly high for some types of mental illness, such as psychotic disorders. Per-person costs are much lower for mood disorders (such as depression), but due to their high prevalence, aggregate costs are very high.[1]

Figure 1.1. **Economic costs of mental disorders in Sweden are enormous**

Economic and social costs of mental health problems in Sweden, 2010




*Note*: A number of cost items are not accounted for due to lack of data or lack of consistent valuation methods. Examples are indirect costs resulting from premature mortality, reduced well-being and crime.

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

## Introduction: definitions and objectives

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).

Understanding the characteristics of mental ill-health is critical for devising the right policies. The key attributes of a mental disorder are: an early age at onset; 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.[2]

The recent OECD report *Sick on the Job? Myths and Realities about Mental Health and Work* identifies two key directions for reform. First, policies should move towards preventing problems, identifying needs and intervening at various stages of the lifecycle; including at school, during the school-to-work transition, at the workplace, and when people lose their job or move into the benefit system. Second steps should be taken towards integrating health, employment and, where necessary, other social services.

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

Administrative data (*e.g.* clinical data and data on disability benefit recipients) generally include a classification code on the diagnosis of a patient or recipient, based on ICD-10. In such case, data measuring the existence of a mental disorder are readily available. This is also the case in Sweden. These administrative data do not include detailed social and economic variables necessary to assess labour market outcomes, however, and they also cover only a fraction of all the people with a mental disorder.

Survey data with sufficient information on socio-economic variables, on the contrary, in most cases only include *subjective* information on the mental health status of the sample population. 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. Such instruments allow the identification of people in good and poor mental health. For 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 on the respective instrument 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.

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

This methodology allows comparisons across different mental health instruments used in different surveys and countries. See *www.oecd.org/els/disability* and OECD (2012) for a more detailed description and justification of this approach and its possible implications. It should be emphasised that the aim of the chosen estimation procedure 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 on Sweden, five population surveys are used:

1) Swedish National Health Interview Survey for 2009/11: the mental disorder variable is based on the mental health and vitality items of the SF-12 scale.
2) Living Conditions Survey (ULF) 1994/95 and 2009/10: mental disorder categories are built on three questions asking whether the respondent "suffers from nervousness, uneasiness or anxiety"; three answer categories are given (yes serious; yes minor; no); the first two are used to estimate severe and moderate mental disorder, respectively.
3) Living Conditions Survey of Children (ULF-Barn), 2009/10: the mental disorder variable is built on six items: have headaches, stomach ache, difficulty falling asleep, feeling stressed, tired during school day and slept badly.
4) Eurobarometer for 2005 and 2010: the mental disorder variable is based on a set of nine items: feeling full of life, feeling tense, feeling down, feeling calm and peaceful, having lots of energy, feeling downhearted and depressed, feeling worn out, feeling happy, feeling tired.
5) The European Working Conditions Survey (EWCS) for 2010: the mental disorder variable is based on a set of five items: feeling cheerful; feeling calm; feeling active; waking up fresh and rested; life fulfilling.

These instruments do not identify exactly the same population but instead cover very similar ones. The quality and reliability of the estimate varies, depending on whether the instrument used has been validated or not. The quality of the ULF survey is lower than that of all other surveys. Direct questions as used in this survey tend to underestimate the true number of people suffering from mental illness. However, the numbers identified as mentally ill in the ULF data set through the approach described above are 3.6% and 15.2%, respectively, for severe and moderate mental illness. This is very close to the prevalence distribution of 5% and 15%, respectively, as derived from epidemiological research.

Notwithstanding the evident major costs of poor mental health in many OECD countries, policies and institutions are not addressing mental ill-health sufficiently. Four core priority areas are identified in the latest OECD report, which need urgent policy attention. These include:

- *Schools* to protect and promote the mental health of children and young people and promote transition services to help vulnerable youth access the labour market successfully.
- *Workplaces* to protect and promote mental health in order to prevent illness and reduced productivity arising in the workplace and labour market exit of those still employed.

- *Employment services* for beneficiaries of long-term unemployment, sickness and disability benefits who are outside of the labour force.
- *Mental health services* which need to be designed and delivered in a way that assists people of working age in their return to work.

In the context of these challenges and priority areas for policy action, the purpose of this report is to examine how policies and institutions in Sweden are addressing issues of mental ill-health and employment:

- How are the critical institutions – schools, workplaces, employment services and psychiatric services – organised and resourced to identify people with a mental disorder?
- What types of actions are taken, and how quickly, once a problem is identified?
- What general prevention policies are in place and what general support is available for those with unidentified mental ill-health?
- How are the different actors co-operating to ensure people get the right services quickly to access, maintain or return to employment?

The structure of the report is as follows. Chapter 1 sets the scene by: *i)* looking at the key labour market outcomes for people with a mental disorder in Sweden, including key challenges facing young individuals; *ii)* describing the main systems catering for people with mental illness and *iii)* discussing the responsibility of different government layers, *i.e.* national, regional and municipal roles in regard to education, social, employment and (mental) health policies. The remaining chapters of the report analyse the "mental health and work" policy challenges that Sweden is facing by taking a lifecycle perspective: First, looking at the period before a young person enters the job market, *i.e.* the school and education system and the transition into the labour market; second, looking at workplaces and interventions happening under the responsibility of the employer; and third, looking at moments when a person is at risk of falling out of the labour market and entering the benefit system, and pathways to return to the labour market; and finally, looking at the role and contribution of the mental health system in different phases of the lifecycle.

## The outcomes: where Sweden stands

Despite suffering a deep downturn and associated labour-market weakness, the Swedish economy has recovered more quickly than other OECD countries. Unemployment rates are falling but remain significantly higher than before the economic crisis. Employment-to-population ratios also remain below their pre-crisis peak, although they have recently improved and remain among the highest in the OECD (Table 1.1).

Table 1.1. **Economic and labour market indicators for selected OECD countries, 2008 and 2011**

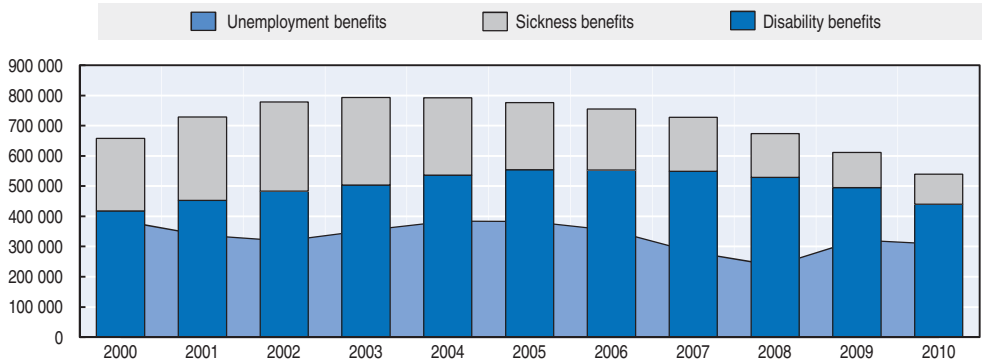
| | Employment population ratio (15-64) | | Unemployment rate (15-64) | | Real GDP growth | |
|---|---|---|---|---|---|---|
| | 2008 | 2011 | 2008 | 2011 | 2008 | 2011 |
| Australia | 73.2 | 72.7 | 4.3 | 5.2 | 1.4 | 2.2 |
| Austria | 72.1 | 72.1 | 3.9 | 4.2 | 1.4 | 3.0 |
| Belgium | 62.4 | 61.9 | 7.0 | 7.2 | 1.0 | 1.9 |
| Denmark | 77.9 | 73.1 | 3.5 | 7.7 | -0.8 | 1.0 |
| Netherlands | 75.9 | 74.9 | 3.0 | 4.4 | 1.8 | 1.2 |
| Norway | 78.1 | 75.3 | 2.6 | 3.3 | 0.0 | 1.4 |
| **Sweden** | **75.8** | **74.1** | **6.1** | **7.6** | **-0.6** | **3.9** |
| Switzerland | 79.5 | 79.3 | 3.4 | 4.2 | 2.1 | 1.9 |
| United Kingdom | 72.7 | 70.4 | 5.4 | 8.0 | -1.1 | 0.7 |
| United States | 70.9 | 66.6 | 5.8 | 9.1 | -0.4 | 1.7 |
| OECD | 66.5 | 64.8 | 6.1 | 8.2 | 0.1 | 1.8 |

*Source*: *OECD Online Employment Database*: *www.oecd.org/employment/database* and *OECD.Stat Dataset* on gross domestic product.

Notwithstanding these relatively favourable economic and labour market conditions, a long-standing problem for the Swedish labour market has been the significant proportion of the working-age population on sickness and disability benefits. Recent reforms to tackle high levels of inactivity among the working-age population have borne some fruit. This is reflected in falling sickness and disability beneficiary numbers (Figure 1.2). Reductions in sickness benefit caseloads were particularly marked, falling by some two thirds from their peak levels in the early 2000s.

Figure 1.2. **Sickness and disability benefit recipiency is falling but remains very high**

Number of people on sickness, disability and unemployment benefits, 2000-10



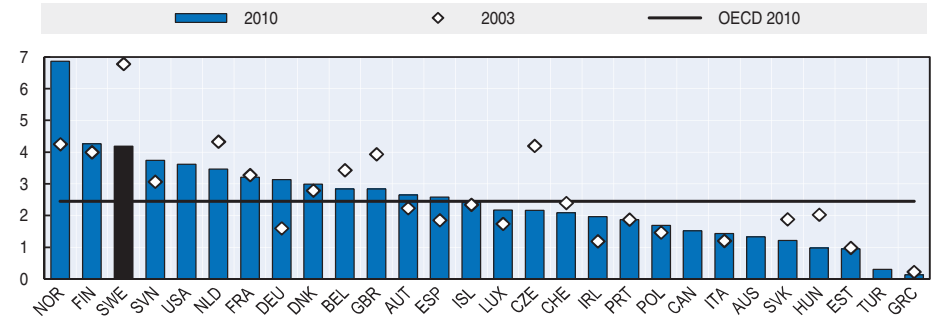

*Note*: Sickness data are annual averages of monthly estimates.

*Source*: Sickness and disability data from the OECD questionnaire on disability; unemployment from the *OECD Active Labour Market Database*.

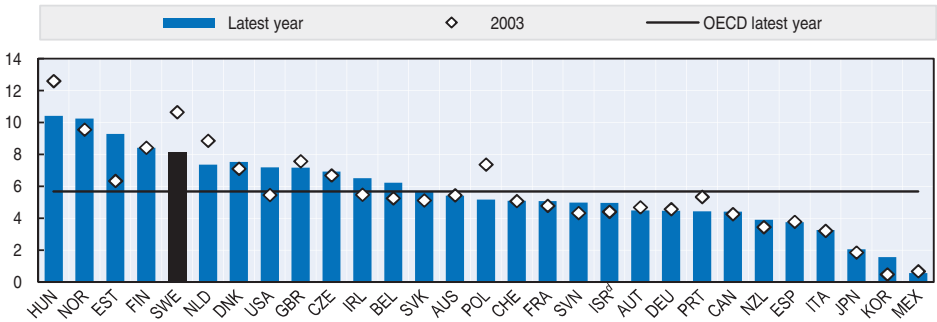
But challenges remain; the incidence of sickness absence in Sweden still exceeds the OECD average, while the number of people not working because of disability is still very high (Figure 1.3). At the end of 2010, some 8% of the working-age population was receiving a disability benefit, compared with only 5% on unemployment benefits. Sickness and disability beneficiaries still account for the majority of working-age people without work.

Figure 1.3. **Sickness absence and disability benefit recipients remain high by international standards**

**Panel A. Incidence of sickness absence of full-time employees in selected OECD countries, 2003 and 2010[a, b]**




**Panel B. Trends in disability recipiency rates, 2003 and latest year available[b, c]**




*Note*: 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.

a. 2004 for Australia, 2007 for Iceland, 2008 for the United States and 2009 for Ireland.
b. OECD is the unweighted average of the countries shown in the chart.
c. Data refer to 2005 for Hungary and the Slovak Republic instead of 2003.
d. Information on data for Israel: http://dx.doi.org/10.1787/888932315602.

*Source*: OECD questionnaires on mental health and disability; *OECD Absence Database*, based on European Union Labour Force Survey for European countries and national labour force surveys for Australia, Canada and the United States.

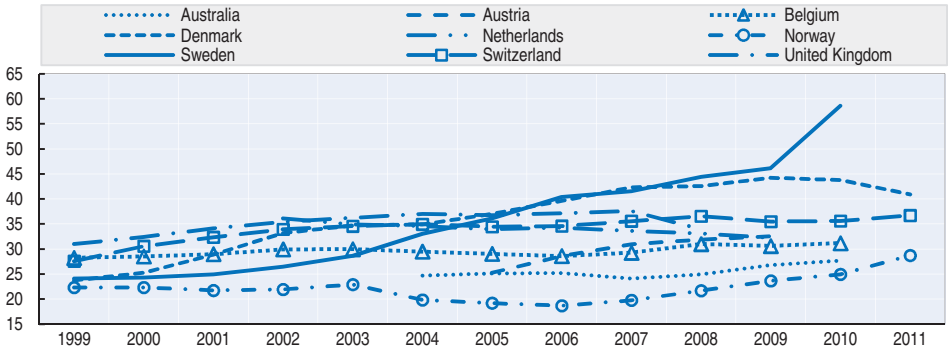
Mental ill-health accounts for a large and growing proportion of incapacity-related absences from work and a large fraction of disability benefit claims. Indeed, mental health issues have become one of the leading causes of labour-market exclusion in Sweden. Mental illness now accounts for around 60% of new disability benefit claims (Figure 1.4). This is by far the highest proportion among countries for which data are available.

At the same time, mental ill-health also presents a challenge for other working-age benefits. Figure 1.5 shows that a large number of people with mental health problems rely on unemployment or social assistance benefits. For instance, social assistance receipt is more than five times as frequent for people with a severe mental disorder and twice as more frequent for those with a milder disorder than for those without a disorder.

The dependency of persons with mental disorders on a range of social benefits can be attributed to their poor labour-market integration. As seen in other OECD countries, people with a mental disorder in Sweden are less likely to be employed than people without mental health problems, with the employment rates being 58% and 74% respectively (Figure 1.6, Panel A). Despite the general labour market improvement prior to the onset of the recent economic crisis, the employment rate of people with mental disorders in Sweden did not increase much between 1994 and 2009. As a result, the employment gap between the two groups widened from 12 to 16 percentage points.

Figure 1.4. **Most new disability benefit claims in Sweden are now due to mental illness**

New disability benefit claims due to mental disorders (in percentage of total claims)

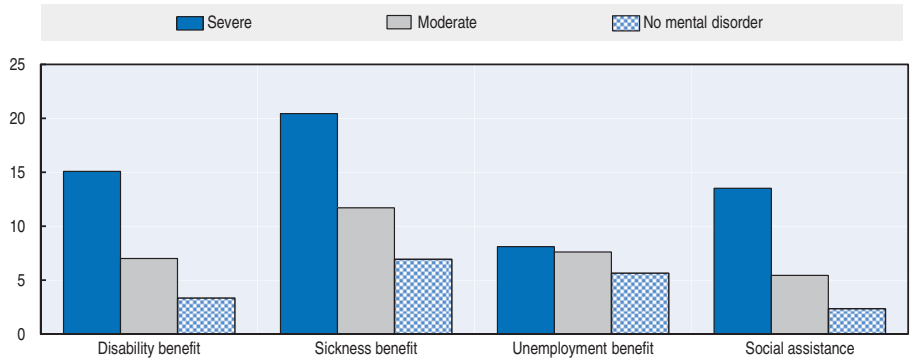



*Note*: Norway does not include the temporary benefit. Belgium, the Netherlands and Sweden include mental retardation, organic and unspecified disorders which on average account for 13.4% of the share of mental disorder inflows.

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

Figure 1.5. **Many persons with mental disorders also rely on unemployment and social assistance**

Proportion of people receiving a disability, sickness or unemployment benefit or a social assistance payment, by mental health status, 2009/10




*Note*: For data limitations caused by the choice of the mental health variable in the survey, see Box 1.1.

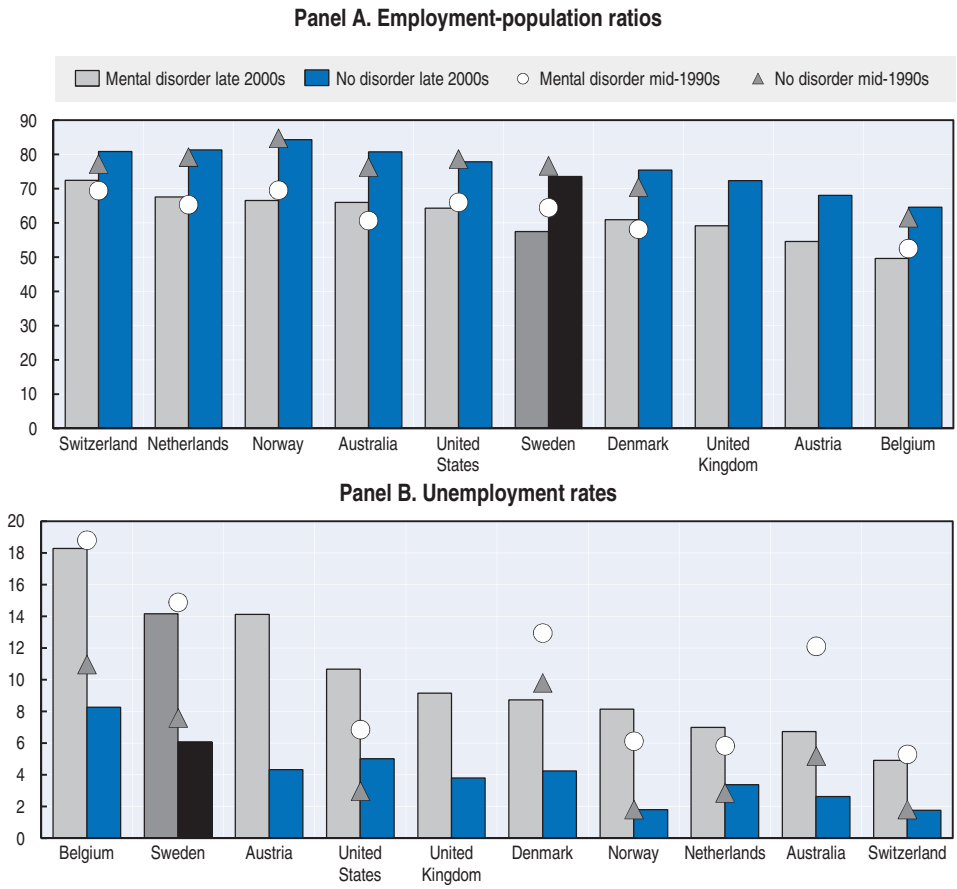
*Source*: Living Conditions Survey (ULF), 2009/10.

At around 14%, unemployment rates of people with a mental disorder are more than twice as high as for people without (Figure 1.6, Panel B). Among comparator countries, this is the second-highest unemployment rate. The high unemployment rates may suggest that people with mental illnesses would like to work but experience greater difficulty in finding jobs.

Meanwhile a majority of persons with a mental disorder, who manage to stay in employment, are facing major problems on their job. They take more sick leave and, as in other OECD countries, are far more likely to report performance problems while at work. In Sweden, 84% and 72% of those with a severe and moderate mental disorder, respectively, are reporting performance problems, compared with 25% of their peers without a mental disorder (Figure 1.7).

Reflecting their weak labour market integration, people with mental ill-health are at a higher risk of income poverty than their counterparts. The poverty risk for people with a mental disorder reaches 20-30% in many OECD countries, including in Sweden (Figure 1.8). The difference of poverty *rates* by mental health status is greater in Sweden than in Austria or the United Kingdom, although it is less pronounced than in other Nordic countries. The lower poverty *gap* could be explained by the relative generous benefit system in Sweden which prevents persons with sickness and disability falling into extreme poverty.

Figure 1.6. **Employment-population ratios and unemployment rates, by mental disorder, mid-1990s and late 2000s**

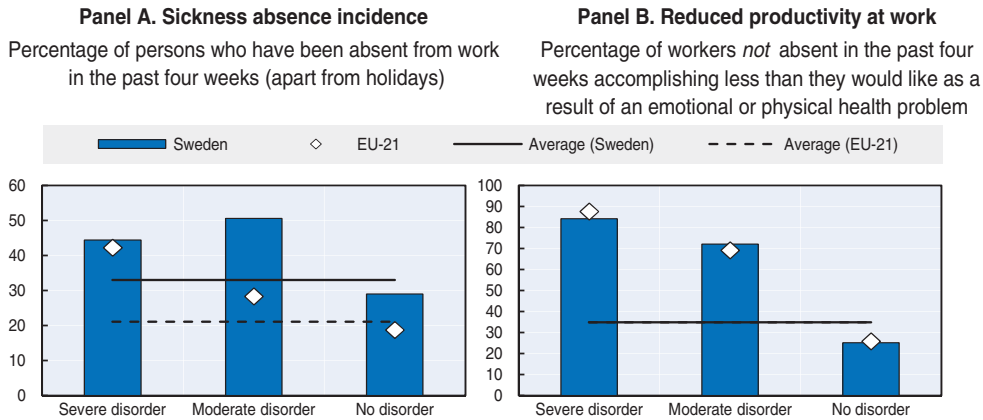



*Note*: For data limitations caused by the choice of the mental health variable in the survey, see Box 1.1.

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

Figure 1.7. **Most persons with mental health problems are struggling at work**

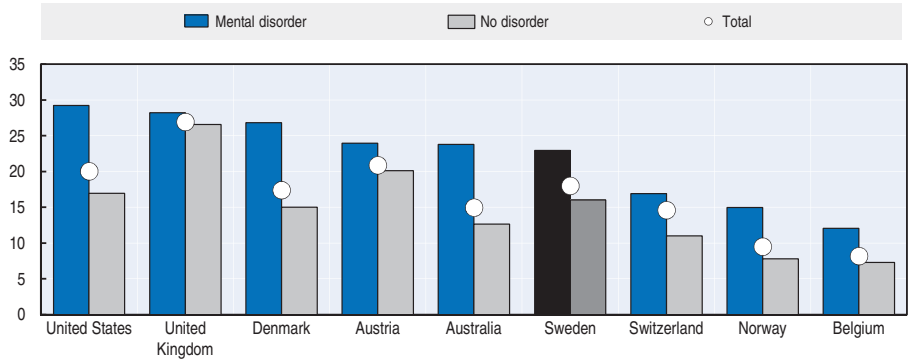
Incidence of absenteeism and presenteeism (in percentage), by mental health status, in Sweden and on average over 21 European OECD countries in 2010




*Source*: OECD calculations based on Eurobarometer, 2010.

Figure 1.8. **People with a mental disorder have a much higher poverty risk**

Poverty risks[a] for people with and without a mental disorder, latest year available




*Note*: For data limitations caused by the choice of the mental health variable in the survey, see Box 1.1.

*a.* The percentage of people living in households with incomes below the low-income threshold (defined as 60% of median income).

*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: Living Conditions Survey 2009/10; Switzerland: Health Survey 2007; United Kingdom: Health Survey for England, 2006; United States: NHIS 2008.

### *Youth and mental health: A rising new challenge*

One of the biggest issues facing Sweden is the alarming number of young adults under age of 25 moving onto disability benefit on the grounds of mental illness, with very little or no work experience. Figure 1.9 shows that under age 25, the number of new claims into disability benefit due to mental disorders has increased by 25% annually over the past decade in Sweden – the largest increase across all OECD countries for which data are available.

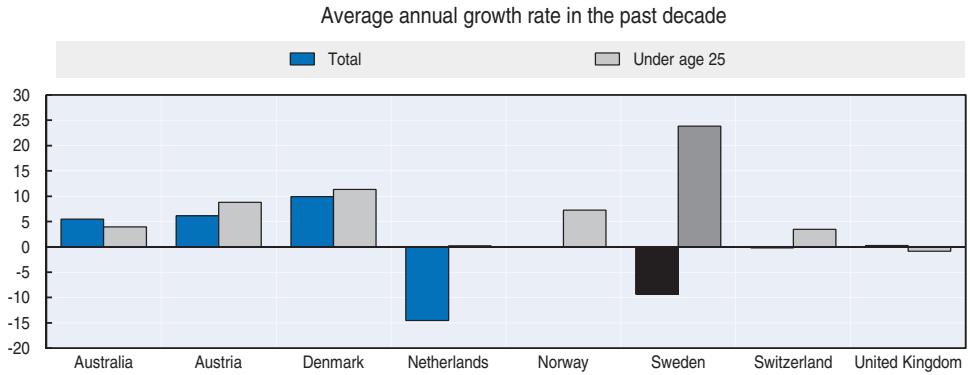
The reasons for the very high and increasing share of mental disorders in new disability benefit claims are complex. Indeed, there is some controversy over what drives these trends. For instance, in line with rising benefit claims, a number of studies in recent years have reported a marked deterioration in mental health of Swedish young people between the ages of 15 to 24, including a doubling, or more, of symptoms such as depression and anxiety, dejection, sleep disorders and self harm (Royal Swedish Academy of Sciences, 2010; Ahrén 2010). And it is not only self-reported symptoms which have become more common; mental ill-health is also reflected in increased hospitalisation of young people with depression and states of anxiety (Figure 1.10, Panel A). An even larger number of patients suffering from a mental illness are treated as outpatients (Panel B).

Although at first sight, the growing number of young individuals on disability benefit seems to be the result of an increase in mental ill-health prevalence, ample epidemiological and clinical empirical evidence suggests that the rate of mental illness is not rising. The recently published OECD report *Sick on the Job?* (OECD, 2012) argues that the shift in the structure of new disability claims towards mental disorders is partly the consequence of the gradual reduction in stigma and discrimination and greater public awareness, which may have lead to greater cases of mental disorders being identified and disclosed. Other important factors include the competence of caseworks in assessing work capacity of those with mental health problems.

Regardless of this paradox, the causes behind the mental health problems of young adults and the mechanisms that translate this trend into long-term benefit dependency at an early age need to be better understood so as to avoid the enormous societal costs this development creates.

Figure 1.9. **Disability benefit claims due to mental disorders among young adults have increased the most in Sweden**

New disability benefit claims with mental health conditions for youth under age 25 and working-age population[a, b]



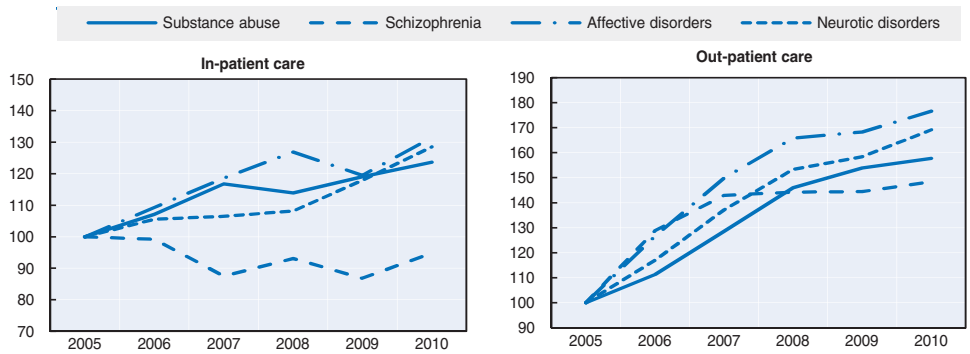

a. Trends refer to the following periods: Australia 2004-10, Austria 2005-09, Belgium 1999-2010, Denmark 1999-2011, Netherlands 2002-09, Norway 1992-2007, Sweden 2003-10, Switzerland 1995-2011 and the United Kingdom 1999-2010.

b. Norway does not include the temporary benefit. Belgium, the Netherlands and Sweden include mental retardation, organic and unspecified disorders which on average account for 13.4% of the share of mental disorder inflows.

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

Figure 1.10. **In-patient and out-patient care in Sweden has grown considerably among young adults**

Per 100 000 inhabitants, aged 15-25, index 2005=100




*Source*: National Board of Health and Welfare.

## The context: systems and institutions

As a necessary backdrop to the policy discussions in the following chapters, this section provides a description and an assessment of the three main systems catering for people with mental illness: social protection and income support, the education system, and health care.

### *Social protection and income support in Sweden*

The Swedish system of social protection is characterised by the payment of comparatively generous benefits – although benefit levels have been reduced in recent years – and by the fact that most benefits are insurance-based rather than means-tested. The basic components of the Swedish social insurance system are old-age pensions, parental benefits, sickness benefits, invalidity benefits, and unemployment benefits. In what follows, sickness, disability and unemployment transfers are most relevant and are described in more detail.

#### *Sickness and disability programmes*

The Swedish sickness and disability compensation system underwent significant reforms over the past decade. As part of these reforms, three key compensation systems were created and are still in use today. These include, *i)* a sickness benefit scheme for workers or jobseekers with temporary illnesses; *ii)* a disability benefit scheme (Activity Compensation) for 19-29 year-olds with reduced work capacity; and *iii)* a disability benefit scheme (Sickness Compensation) for individuals with permanent impairments who are aged 30 or above.

Since 2005, the primary responsibility for administering sickness and disability programmes in Sweden lies with the national Swedish Social Insurance Agency (SSIA). Prior to the 2005 reforms, SSIA operated 21 regional offices making somewhat autonomous decisions about client assessment and benefit entitlement.

#### Sickness benefits

In general, the temporary sickness benefit amounts to a compensation level of 80% of previous earnings, up to a maximal annual limit, which is 7.5 times the Price base amount or SEK 321,000 in 2011. It is paid for 364 days within a timeframe of 450 days. If the illness continues, an extended sickness benefit is paid at a level of 75%, usually for a maximum of additional 550 days. In total, it is possible to receive sickness benefit and extended sickness benefit for a continuous period of 914 days, or about 2.5 years.

Depending on the duration of the sickness absence, responsibility for benefit payments is shared between the employer and the SSIA. Following a one-day waiting period, the employer covers the subsequent 13 days, while the SSIA pays sickness benefits for the remaining period. Unemployed workers can also be eligible for sickness benefits as long as they are registered at a local employment office as a job seeker and have a previous history of employment. The SSIA is responsible for any sickness benefit payments to the unemployed (again, subject to a one-day waiting period).

The social insurance system contains some control instruments to prevent unjustified use of sickness insurance. After reporting sick by contacting either the employer (employed workers) or the SSIA (unemployed), the benefit claimant must visit a doctor within seven days of reporting sick to continue receiving support. From eighth day onwards, a doctor's certificate must be provided to the SSIA covering the entire sickness period for which sickness benefit is granted.

### Disability benefits

Sweden is among the very few OECD countries that provide a separate disability scheme for young adults. Activity Compensation is paid to persons aged between 19 and 29 on the condition that they have suffered an illness that reduces their work capacity by at least a quarter and for at least a year. Benefits are paid for a limited period of at most three years at a time; entitlement is reassessed thereafter. Disability benefit can be both income-related and in the form of guarantee benefit. Full income –related disability benefit amounts to 64% of an average of the three highest previous gross yearly incomes. Those with no or very low income receive a guarantee. The maximum guarantee level amounted to SEK 102 720 per year in 2009.

Eligibility conditions are largely similar under the disability benefit for those aged over 29 (the Sickness Compensation). Before July 2008, benefits could be awarded on a temporary basis (for a period of at most three years, as in the case of the Activity Compensation). Under the new rules, only permanent disability benefits are allowed.

### Unemployment benefits

Eligibility criteria for unemployment benefit, including entitlement conditions (employment and contribution requirements to gain access to benefits) and requirement to actively look for work or take part in active labour market programmes, are relatively strict (Venn, 2012). Unemployment benefits are paid for a maximum of 300 days (60 weeks) and for 450 days for parents with dependants. After expiration of 300 days, all unemployed receive "Activity Support" conditional upon participation in the active labour market

programme known as the Job Development Guarantee (JDG) which lasts for a maximum of 450 days. (See Box 1.1 for details on activation requirements for the unemployed and long-term unemployed in Sweden.)

The public unemployment insurance (UI) comes under the jurisdiction of the Ministry of Employment, although it is administered by the trade unions' unemployment insurance funds. The contribution from the trade unions' funds covers approximately 30% of the costs, with the reminder financed through state subsidies since 2007.

The unemployment benefit consists of two parts: a mandatory basic insurance and voluntary income-related insurance. Around 90% of all workers in Sweden contribute to the voluntary scheme. This entitles them to up to 80% of their former salaries (maximum of SEK 680 per benefit day) for their first 200 working days (40 weeks) of unemployment (see Table 1.2 for eligibility conditions and benefit amounts). The following 100 days (20 weeks) are paid at 70% of previous earnings (maximum period of one year). However, effective replacement rates are much lower, as payments are capped at 50% of average full-time earnings; only people on relatively low incomes will receive 80% of their previous earnings.

Table 1.2. **Characteristics of the Swedish unemployment insurance**

| Employment (E) and contribution (C) conditions | Insurance for employees | Waiting period (days) | Maximum duration (months) | Payment rate (% of earnings base) | | Minimum benefit | | Maximum benefit | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Initial | At end of legal entitlement period | National currency | % of AW | National currency | % of AW |
| E: 6 months in last year, C: been a member of an insurance fund for 12 months. | Voluntary | 7 | 35 | 80 | 70 (after 9 months). 65 for Job and Development Guarantee (after 14 months). | 83 200 | 23 | 176 800 | 48 |

AW: Average wage.

*Source: OECD Tax-Benefit Policies Database, www.oecd.org/els/social/workincentives.*

Jobseekers who have not joined a voluntary insurance fund, or have not been a member for a full year, are entitled to a basic payment of SEK 320 per insurance day, irrespective of previous income. The maximum duration of payment is also 60 weeks.

As in other OECD countries, young unemployed face stricter benefit rules. Recipients of the earnings-related benefit see it decline faster.[3] Young persons who are over 20 and not entitled to the income-related benefit or to the basic allowance and have completed upper secondary education receive

an allowance of SEK 135 per day, while 18-20 year-olds who have not completed upper secondary education receive SEK 48 per day, corresponding to the study allowance for students in upper secondary education. After 100 days, youth are obliged to participate in the "job guarantee for youth" programme to receive these benefits.

Unemployed persons who are not covered by unemployment insurance because they do not satisfy work requirements can instead obtain social welfare benefits, which are administered and financed by the local governments. The standard level of basic living cost for a single adult is SEK 2 800 per month (*OECD Tax-Benefit Policies Database*). According to the Social Services Act recipients of social assistance who are able to work are required to search for jobs and participate in active labour market programmes (ALMPs).

### *Brief overview of the education system*

The Ministry of Education holds the overall responsibility for schooling and is in charge of developing the curricula, national objectives and guidelines for the education system. Municipalities and independent providers are responsible for implementing educational activities, organising and operating school services, allocating resources and ensuring that the national goals for education are met. The organisation of schooling within municipalities is further decentralised with a large degree of autonomy delegated to school districts and individual schools.

Education in Sweden is mandatory for 7-16 year old children, during which they attend a primary school known as "Grundskola". Following this comes an elective three year secondary school, "Gymnasieskola" which is divided in two parts where you either prepare for higher education or receive vocational education. Completing secondary schooling provides a basis for higher education, *i.e.* entrance to a university.

The general education policy towards children with special needs is to keep and help them within mainstream schools. No data are available on the number of pupils with special needs in schools and their corresponding diagnosis, but this group is likely to include children with milder mental disorders who require special attention. Other schools include special schools (*specialskolor*) and schools for students with intellectual disabilities (*särskolor*). These schools are targeted at children with severe functional problems and disabilities that are out of scope of this report.

### *The mental health care system*

The responsibility for health care is divided between three political governing levels; the national government, the regional county councils and the local municipalities. Overall responsibility for the health care sector rests, at the national level, with the Ministry of Health and Social Affairs, while 21 county councils are responsible for the funding and delivery of healthcare, and 290 municipalities are responsible for long-term care for the elderly and the disabled. The National Board of Health and Welfare (NBHW) (*Socialstyrelsen*), a semi independent public authority, has an important supervisory role over the county councils and has the duty to follow up and evaluate the services provided in order to see if they correspond to the goals laid down by the government.

Psychiatric care is an integrated part of the health care system and is subject to the same legislation as all other health care services. This leaves considerable room for the county councils to decide on both mental health care process and content, *i.e.* what to deliver and how to do it.

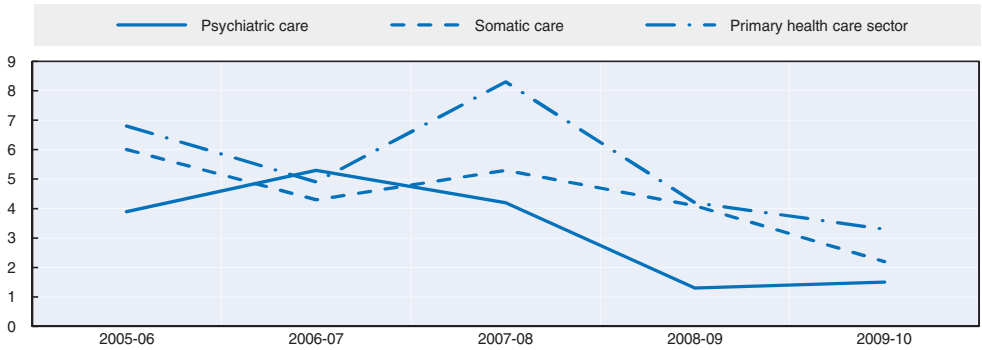
As in other OECD countries, mental health services in Sweden have undergone significant changes over the past three decades, with a clear emphasis on developing outpatient care. Inpatient care has greatly decreased. In 1980, there were 3.2 number of beds for every 1 000 residents, but only 0.5 per 1 000 population in 2009 (*OECD Health Database*). Most of the Swedish, stand-alone mental hospitals have closed and have been replaced by inpatient care in psychiatric clinics in general hospitals, supplemented by small nursing homes. As a result, remaining beds have been used for more severely impaired patients (Silfverhielm and Kamis-Gould, 2000). At the same time, the responsibility for the care of patients not needing hospitalisation is now managed by the local communities. Most of the patients with major psychiatric disorders are not seen by mental health specialists, but instead by their primary health-care providers.

The challenge in Sweden has been to balance community-based and hospital mental health care. There are some concerns that specialised psychiatric care has fallen to its minimum level. The increase in expenditure for specialised mental health care has been systematically lower than for somatic care and primary health care since 2006 (Figure 1.11). In 2010, specialised psychiatric care accounted for only 9% of the total net costs for health care in Sweden (SALAR, 2010). Arguably, inadequate financial and human resources contribute to the lack of adequate mental health care and the large gap between the number of people in need and those that receive care. Moreover, the decline in specialist psychiatric care is likely to further increase the burden on primary health care centres that are confronted with dealing with persons with moderate mental health disorders. The recent

National Action Plan of the Swedish Government *From Vision to Action-a Policy for Mental Health* has committed to boost spending on mental health care services but it is too early to tell whether the response is sufficient to tackle this large-scale issue.

Figure 1.11. **The costs for psychiatric care increase at a lower speed than costs for somatic care**

Annual change (in percentage) of net costs in healthcare expenditure, Sweden, 2005-10




*Source*: Swedish Association of Local Authorities and Regions (SALAR).

## Conclusion

In conclusion, the following facts emerge in comparing sickness and disability policy outcomes and the labour market situation of persons with mental disorders with those in other OECD countries.

- Sickness absence rates still exceed the OECD average although they have fallen remarkably since 2005. Similarly, dependency on disability benefits remains high albeit the recent reductions in the large caseload of disability recipients.
- Mental ill-health has become one of the biggest drivers of inactivity with up to 60% of all new claims into disability benefit due to mental disorders. This increase is particularly large for young persons aged 16 to 24; this is a universal trend in many OECD countries but it is more pronounced in Sweden.
- As in most other OECD countries, employment rates of persons with mental disorders are around 15 percentage points lower than those of their peers without mental disorders, while unemployment rates are more than double. Persons with mental disorders are at a higher risk of poverty, but they vary only slightly by mental health status compared with other OECD countries.

## *Notes*

1. As in many other OECD countries, depression is one of the most common diagnoses in primary care in Sweden (Tiainen and Rehnberg, 2010).
2. The diagnosis also matters, but mental illness of any type can be severe, persistent or co-morbid. The majority of mental disorders fall in the category mild or moderate, including most mood and anxiety disorders.
3. Gross replacement falls from 80% to 65% after 200 days compared to 300 days for those above 25.

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# *Chapter 2*

# Youth in Sweden, mental ill-health and the transition into the labour market

*The purpose of this chapter is twofold. First, it assesses whether the school system can adequately identify and manage mental health problems of children and youth. Second, it examines the role of transition services offered* e.g. *by the public employment service and local employment services to help vulnerable youth enter the labour market. It discusses strategies to prevent mental health problems in schools and the effectiveness of school health services in dealing with mental disorders. It reviews policies directed at identifying problems among early school leavers and young adults who are not in education and not in employment and who are generally at a greater risk of developing mental disorders. The chapter also examines the employment programmes to boost labour market demand for vulnerable youth and addresses the main problems in the disability benefit system for young people.*

Up to 50% of mental disorders have their onset during adolescence (OECD, 2012a). Consequently, childhood and adolescence are critical periods for developing the foundations of mental health and tackling mental ill-health. Mental disorders during childhood are disruptive in attaining good education and considerably weaken the chance of labour market participation later in life. In turn, if left untreated, these factors will operate as a significant constraint to future labour supply, economic growth and the welfare of society more generally.

Sweden appears vulnerable to this risk. Deterioration in mental health and well-being is becoming increasingly common among young Swedish people. Related to this, the increasing trend towards young people accessing disability benefits due to mental health problems is alarming. Early intervention and support is therefore critical to support vulnerable pupils with mental health problems to ensure good academic achievement and a successful transition into the labour market, while preventing unnecessary labour market exclusion through early moves onto disability benefits (Barlow *et al.,* 2007; OECD, 2010a).

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

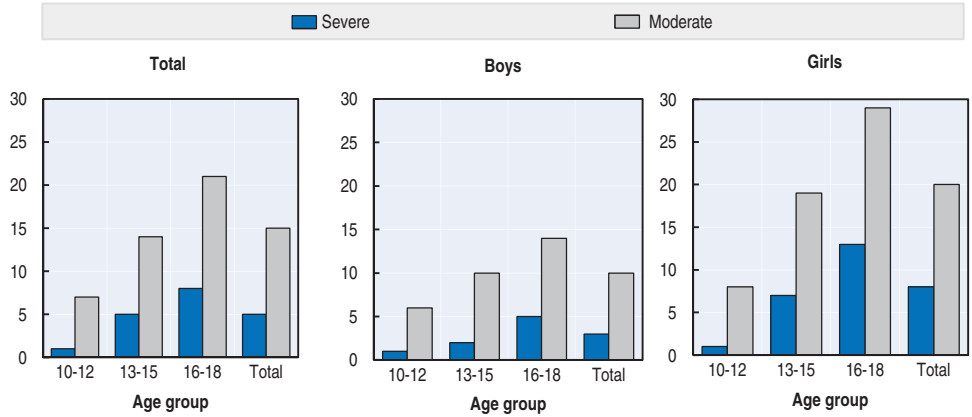
Schools provide an ideal setting for early identification of children and young people at risk of developing mental health problems, to offer early prevention and refer them to specialist care and treatment if need be (Domitrovich *et al*., 2005).

Figure 2.1 shows that a significant proportion of school pupils require mental health related support. One in five Swedish children aged 10-18 years suffer from a mental disorder. Problems are much more prevalent among upper-secondary school pupils (age 16-18). Moreover, although mental health complaints are more prevalent in girls across all ages, the gender differences are striking in upper secondary schools, where almost twice as many girls as boys feel depressed.[1]

The rising mental health problems with age also indicate the intensification of problems in the transition from compulsory to upper-secondary school. This highlights the urgent need for action during this period to ensure successful transitions into higher education and to the labour market.

Figure 2.1. **Mental disorders among pupils in schools are high**

Proportion of youth with a mental disorder, by age and gender




*Note*: Prevalence levels by age and gender should be interpreted with caution because of the chosen methodology to predefine 20% of the population as having a mental disorder (Box 1.1)

*Source*: OECD calculations based on the Living Conditions Survey of Children (ULF-BARN), 2010.

### *School health and welfare services are responsible for early intervention in mental health problems*

According to the Education Act in Sweden, all students are entitled to school health and welfare services. The primary role of school health and welfare services is to promote the mental and physical development of all students by mitigating individual and other risk factors (*e.g.* abusive treatment, tobacco, alcohol, drugs, etc.) and by providing a positive, friendly and open social environment at school. Services are usually delivered by school doctors, nurses, psychologists, school social workers and a special education teacher. The extent to which school health staff is involved in mental health issues is highly heterogeneous (Box 2.1).

The school health interview offers the greatest potential to identify pupils' mental health problems and to focus attention on critical variables that can affect student outcomes. But, most school nurses set aside only 20 minutes for each interview, which – as it covers a wide range of health issues – may not be enough for identifying mental health problems.

Generally, a more comprehensive access to, and support by, services is driven by student academic performance *i.e.* when a student is at risk of not achieving the minimum proficiency or targets in school. Poor school performance would usually trigger an assessment for special needs which is carried out by a team involving a special education teacher, a psychologist, a

counsellor and a school nurse. An action plan will be drawn up if the assessment indicates a need for special support. The range of support may vary according to the special needs of a student and can address anything from mental health to social conditions of students.

Box 2.1. **Who provides mental health services in Swedish schools?**

School health and welfare services employ school psychologists, school social workers, and school nurses who provide a range of mental health supports to students and their families. These professionals, however, provide services within the scope of their training and experience, and therefore, the services offered by individual professionals vary.

In Sweden, school nurses spend around 80% to 90% of their time dealing with pupils' work environment and participating in procedures related to pupils' extended absences (NBHW, 2010a). School social workers are much more active in work related to mental health of individual cases as well as preventative work. For instance, they are involved in anti-bullying activities and make further investigations for children showing signs of mental ill-health as well as make referrals to specialist support and services.

School psychologists allocate most of their time dealing directly with pupils with mental health problems. They spend significant time diagnosing and working with pupils with school problems and investigating their school difficulties or behavioural problems, and on giving personal advice and guidance to pupils and maintaining contact with parents. Other activities offered by school psychologists include group sessions with pupils and advice to, or consultative supervision of, school staff.

Sweden operates an explicit framework for addressing health care problems in schools and there has been a shift in expectations that school health care should play an active role in addressing mental health issues of adolescents and youth. Despite this, several challenges exist in school-based mental health care.

### *Awareness of mental health issues among school medical staff is weak*

According to a survey conducted by the National Board of Health and Welfare (NBHW) on the quality of school health services in relation to pupils' mental health, only a third of local councils said that guidelines for school doctors contained particular instructions to monitor the mental health of pupils (Table 2.1). Municipalities also tend to give little attention to mental health problems of particular target groups of children and youth. Only a third of municipalities have guidelines for nurses to monitor mental health of pupils with chronic illness or disability, and 29% for those who have been under care of social services or child psychiatry; guidelines for children from poor psychosocial risk environments are virtually non-existent.

The problem is worse for social workers and school psychologists for whom there are few or no guidelines on handling cases with mental health problems (NBHW, 2010a). For instance, the Education Act stipulates that school health services should consist of psychologists and social workers, yet it provides no clear indications on what school social workers and psychologists are legally obliged to do. As a result, the degree to which the skills of psychologists and social workers are used in schools varies as a function of school funding, school policy, and the primary employer of psychologists and social workers.[2] A lack of explicit guidelines not only threatens the consistent delivery of appropriate services for those who need them, but hinders the evaluation of service quality and monitoring of personnel in case of non-compliance.

Table 2.1. **Little attention is given to mental health conditions in guidelines for selected school medical staff**

Share of municipalities with directives for school medical staff with a focus on children's mental health

| | Assignment documents (%) | Includes mental illness (%) |
|---|---|---|
| School doctors | 42 | 31 |
| School nurses | 48 | 48 |
| Of which documents contained specific instructions on mental health of students with: | | |
| Chronic illnesses and disabilities | 32 | .. |
| Poor psychosocial risk environments | 1 | .. |
| Contact with social services or child psychiatry | 29 | .. |

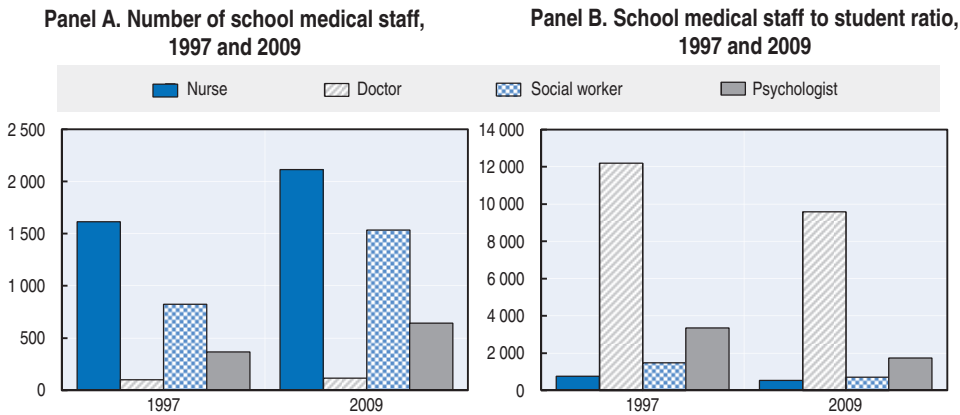
*Source*: Survey on Children's Health in School, National Board of Health and Welfare, 2010.

### *Most schools have insufficient resources in dealing with mental health problems at schools*

Access to school doctors, school nurses, psychologists and social workers remain a major problem. There is serious lack of resources for student health services, resulting in very high student-to-staff ratios; on average, a school nurse is responsible for 800 students, a school doctor for 10 000 and a psychologist for 2 000 students (Figure 2.2, Panel B). In light of the growing self-reported mental health among children and adolescents, the National Health Board over the past few years has increased resources in schools to better assess student's emotional well-being and identify barriers to student development. During this period, the number of school nurses increased by 14% and the number of school therapists by 23% in municipal schools (Figure 2.2, Panel A). But outcomes are still disappointing.

Insufficient access to specialist support from psychologists leads to long waiting times. Waiting times in schools far exceed national guidelines for child and youth psychiatry, according to which a child should be able to see psychiatrists within 30 days. In municipal schools, the waiting time to see a school psychologist on average is more than two months, while in private schools, pupils may have to wait up to 22 weeks (Table 2.2). The significantly longer waiting times in private schools are of great concern since the proportion of students in independent schools is growingly steadily. The relatively long waiting time to see a school psychologist poses particular problems for pupils with mental health problems in those parts of the country where referral to a psychiatric unit is conditional on prior examination by the school psychologist.

Figure 2.2. **Access to school nurse, doctors and psychologist are astoundingly low**




*Source*: Administrative data provided by the Ministry of Education.

Table 2.2. **Waiting times to consult a school psychologist are very long**

Weeks

| | Social worker | Psychologist |
|---|---|---|
| State school | 2 | 10 |
| Private school | 1 | 22 |
| Primary & secondary school | 2 | 11 |
| Upper secondary school | 2 | 16 |

*Source*: Survey on Children's Health in School, National Board of Health and Welfare, 2010.

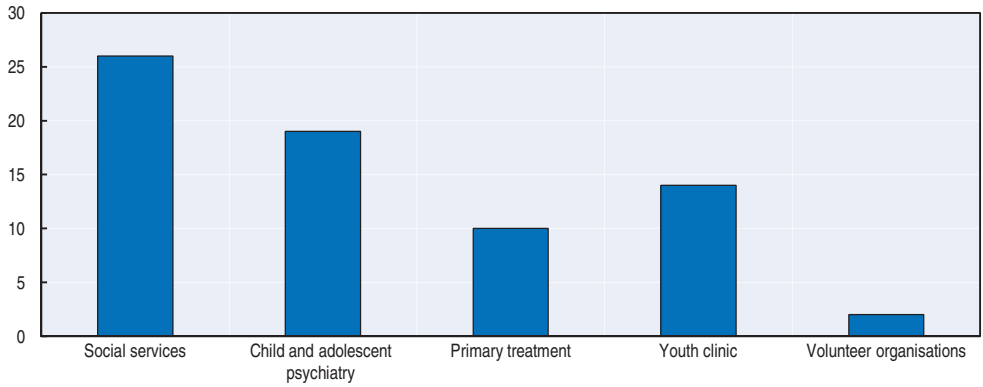
### *Co-ordination between schools and other local actors needs to be improved*

Achieving effective co-operation between schools and other local actors remains a significant challenge in Sweden. Available information suggests a lack of collaboration between school health services – often a crucial entry point for youth to further support and services – and primary care and other special services. Overall, less than a quarter of councils reported co-operation between schools and other actors with different actors that provide complimentary or follow-up services and support (Figure 2.3).

Building strong links with child psychiatric service and primary health care services is particularly challenging, since the latter is in the hands of the regional councils while school health care is under the municipalities. Such a delivery model can lead to uncertainty regarding the responsibilities of the different providers and, potentially, fragmented services.

Figure 2.3. **Co-operation between school and other youth services is low**

Share of municipalities with school health and student care services having a co-operation agreement with another organisation, 2010




*Source*: Survey on Children's Health in School, National Board of Health and Welfare, 2010.

In 2007 and 2008, the National Agency for Education allocated SEK 100 million to projects that encouraged co-operation between schools, police, social welfare and specialist mental healthcare. But these initiatives are not mainstreamed across the country – a reflection of the governance structure built into the Swedish school system, where the central government has no jurisdiction and insufficient information on which models the schools should use.

### *Recent initiatives to improve access to school health care are promising but not sufficient*

Overall, various indicators suggest that the current state of school health services is not adequate. To strengthen these services, the government recently (2011) allocated an additional SEK 207 million for 2013 and SEK 270 million for 2014. The bulk of these funds take the form of a government grant to municipalities and school authorities to hire additional school doctors, nurses, school counsellors, psychologists, and special education teachers and to improve training of personnel in school health services.

However, greater resources in schools alone are not sufficient to ensure an adequate response from those working within school settings. Lack of clear guidelines, limited data collection and absence of evaluation of outcomes also hinder the provision of high quality services. Access to relevant statistics is a particularly important tool for monitoring and developing new policies. Currently, only a few local councils systematically collect data to track the effects of school health care work on pupils' mental health. Information was collected from only 25% of psychologists, 16% of social workers and 32% of school doctors and nurses (NBHW, 2010a). This is partly explained by the fact that most school psychologists and school social workers do not have computer records or work with non-standardised information systems. There are currently no registers at the local, national or regional level where information on the policies and outcomes of the school health and welfare service on mental health is recorded in a unified manner.

Good education and training for teachers and school health personnel is another critical factor for an effective response to mental health needs. Evidence suggests that training for staff working in school health services are well developed and offer specialisation in a range of different topics but increasing knowledge among teachers on how to recognise and intervene appropriately in situations where mental illness may be a concern is also imperative.

### *Mental health promotion in high risk groups*

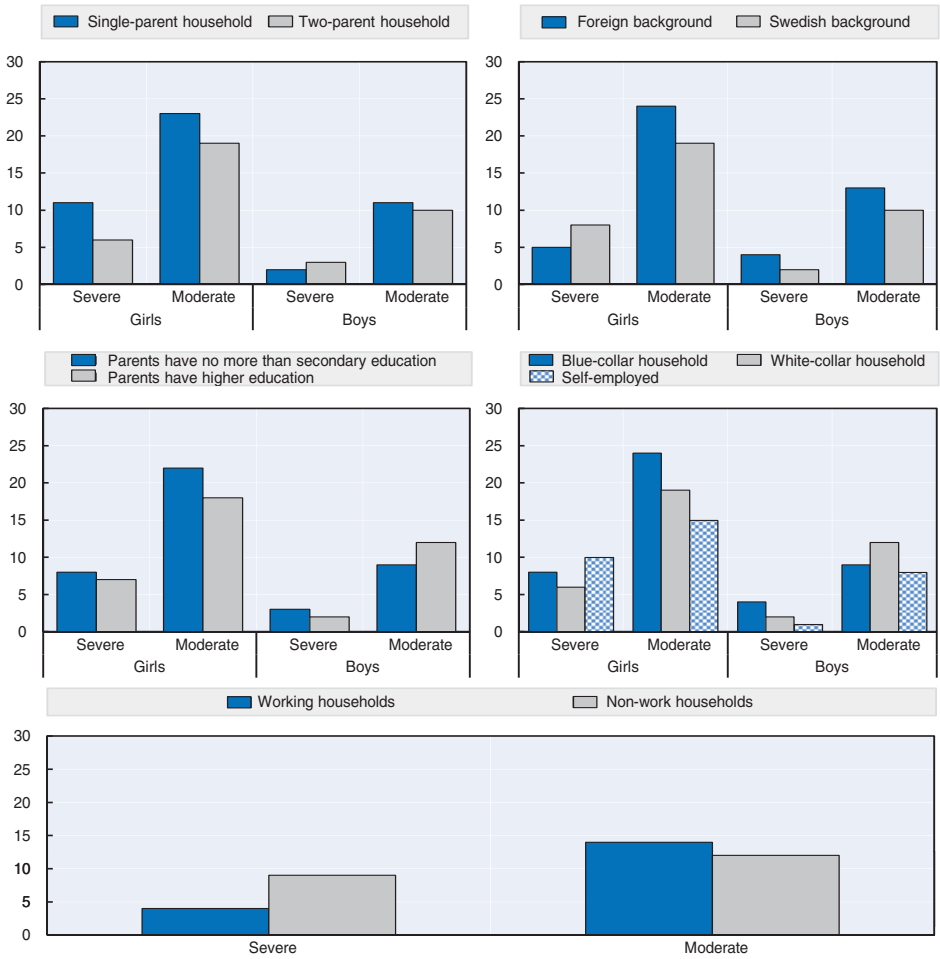
In spite of the broadly preventative measures in schools, certain groups are likely to miss out on school-based mental health services. The problem is accentuated by the pervasive stigma associated with mental ill-health, which acts as a major barrier to identification and disclosure of mental health problems and hinders support. How to reach the group of youth with unidentified and undisclosed mental disorders is therefore an important issue that deserves more attention and research. Another challenge is how to intervene early among those who are known to be at higher risk of developing mental disorders. Ample evidence suggests that some groups of children and

youth are much more likely to develop mental-health problems later on and require targeted support (Sowden *et al*., 1997; Patel *et al*., 2007).

Young people living in single parent households; with a foreign background; with parents who have relatively lower education levels or in low-income households are at greater risk of suffering from a moderate mental disorder (Figure 2.4). Associations of all these factors with mental illness are less pronounced for boys and more blurred in relation to severe mental disorder.

Figure 2.4. **Social disadvantages increase the risk of mental ill-health**

Mental disorder by severity, gender and household characteristics




*Source*: OECD calculations based on the Living Conditions Survey of Children (ULF-BARN), 2010.

In the current state of the Swedish school health and welfare service, which faces limited resources and provides merely basic preventative programmes, it will be important to give targeted support to high risk groups.

## Mental ill-health, school drop-outs and NEET

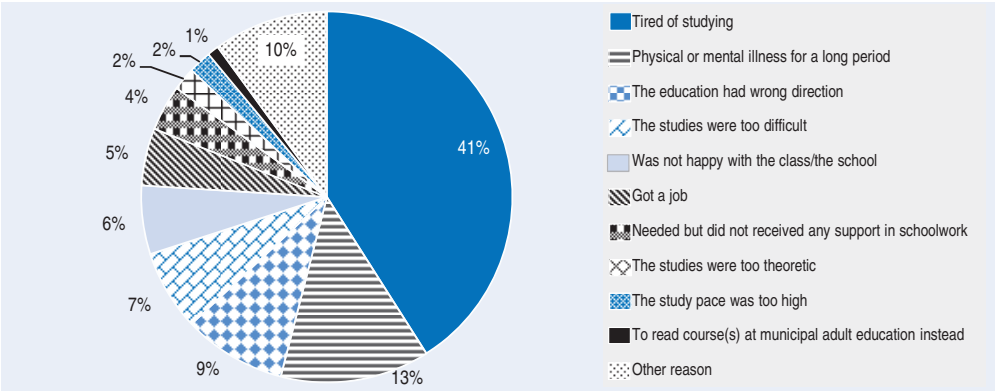
Several studies in Sweden and internationally show that youth with low or incomplete grades from compulsory schools are at significantly higher risk of future psychosocial problems. At the same time, youth who do not enter upper-secondary school, or who drop out early on, already have more difficulties than others in establishing themselves on the labour market. They are more likely to need financial assistance (social security benefit) and have a higher chance of moving onto disability benefits (NBHW, 2010b).

### *Mental ill-health is an important factor in school drop-outs*

Although drop-out rates in Sweden remain below the OECD average, they are increasing. There is near-universal enrolment in upper-secondary schools, but 20% of those enrolled leave secondary school prior to graduating, and a further 10%, do not meet the standard required for general admission to higher education (OECD, 2012b). Unmet needs for services addressing students' mental health problems may contribute to these problems. For instance, according to a study conducted by Statistics Sweden, up to 41% of upper-secondary drop-outs reported that they had left because of school fatigue and one in eight reported that they had dropped out due to a mental or physical illness (Figure 2.5).

Figure 2.5. **Fatigue and illness are the main determinants in school drop-out**

Beginners at upper secondary school who have not completed the studies by reasons for study drop out, 2000




*Source*: Statistics Sweden.

### *Youth not in education nor employment require special attention*

While the association between unemployment and mental ill-health is well established, there is less empirical evidence on the linkages between economic inactivity and mental health. In a recent study, Sellstrom *et al.,* 2010 show that young adults who are not in education and not in employment (NEET) in Sweden had a higher risk of being admitted to hospital due to mental disorders compared with those who are either in school, employed or both.

Other survey data from tell a similar story. Table 2.3 shows the percentage of young people aged 16-24 who experience anxiousness, nervousness or acute anxiety. Poor mental health is significantly more common among the NEET than for any other group. In line with other evidence shown above, the incidence of anxiousness and nervousness is again much higher among young women than young men.

Table 2.3. **The NEET group is at a higher risk of facing mental health problems**

Problems of nervousness, worry or anxiety by main activity, years 2008-09 and 2009-10

| | Men | Women |
|---|---|---|
| Studying | 13.3 | 26.0 |
| Employed (including self-employed) | 11.3 | 27.7 |
| Neither employed nor studying[a] | 26.6 | 36.0 |

a. Data for women have been estimated based on the total incidence of nervousness, worry or anxiety among 16-24 year-olds.

*Source*: Living Conditions Surveys (ULF).

The high incidence of psychological distress among non-employed youth warrants an active effort in NEET prevention and early intervention to help them reconnect with the education system or the labour market. Schools and municipalities are both responsible for tracking school drop-outs and those who have not completed upper secondary education and for providing them with the necessary supports. Current efforts are, however, unsatisfactory.

Under the school law, municipalities are responsible for following up on youth (below the age of 20) who have dropped out of compulsory education and those not in employment or training (known as the municipalities' information responsibility). There are, however, no firm guidelines or strong incentives for follow-up. An evaluation conducted by the Swedish National Agency for Education shows that action plans for the follow-up of youth, who have completed compulsory school but are NEET, are often

non-existent (Swedish National Institute of Public Health, 2011). Furthermore, the review on the follow-up responsibility showed significant deficiencies, including a lack of information on about 30 000 youth under the age of 20, who are outside the education system.

The need for a closer follow-up of the NEET group is illustrated by the fact that when follow-up does take place, municipalities often discover that lacking secondary education is not the primary problem. Many of those in the NEET group have poor psychological and mental ill-health, problems at home, engage in substance abuse and have other issues which require attention. In other words, NEET are at a particular risk of remaining out of the system due to lack of mental health support. At present, there are local variations in the service provided and differences in referral procedures. However, *Youth Clinics* run jointly by municipalities and regions is one very promising delivery model of services to young people with multiple problems, in particular those with psychological issues (Box 2.2).

Box 2.2. **Municipal youth clinics are well placed to tackle mental health problems among youth**

Youth clinics (UM) are an easily accessible public service, free of charge, for youth up to 20 years of age and play an important role in general health promotion because of their close contacts with a large proportion of the teenage population. Around 1.3 million young people have registered with Youth clinics since their inception in 2002. Municipalities or the county council, either separately or jointly, are responsible for the financing of Youth clinics.

All youth clinics consist of at least one midwife, a general practitioner, a social worker and a psychologist. The main activities of the centres include prevention and treatment services to youth with *a)* psychological and social problems and *b)* sexuality issues (*e.g.* unwanted pregnancies and prevention of sexually transmitted infections). Although there are some differences in the way services are organised between municipalities, the general focus of the Youth centres remains the same.

Psychological treatment measures can take the form of shorter or longer therapies of crisis, support and/or insight-focused character. It is then particularly important for these young people that there is access to a psychologist, since advanced diagnostic assessments often have to be made if they are to receive adequate help.

Individual contacts take place on a voluntary basis and make contact through the open house or the “drop-in centre”. The contact can be short or long, and infrequent or frequent. The work of the various professions consists of individual conversations, investigation, treatment, group activities and outreach work including study visits to school classes and informing schools about their services.

The service mix within a single youth-friendly setting is a strong feature of the youth clinics and regarded as an ideal way forward to fill an important gap in view of the poor access and engagement of young people in traditional primary and specialist health care. Integrating mental health programmes and services into general youth and welfare programmes can represent a way forward, notably in low-resource settings. In addition to improving accessibility, one distinct advantage of this model is that youth health and welfare programmes are likely to be less stigmatising when multiple youth-friendly services are provided under one roof (Patel *et al.,* 2007). Workers in youth clinics actively work to identify early signs of mental illness and deal with concerns related to social development of adolescents. However, evaluations of anxiety and depression could become a standard routine among adolescents visiting Youth centres in order to initiate appropriate treatment early in the course of the illness. Furthermore, to increase the effectiveness of services in youth centres, there is a need for consistent evaluation of programmes and practices operating in different municipalities.

## Transition into the labour market

The school-to-work transition is a critical period for all youth to promote a successful start in the world of work. Evidence shows that a successful transition to work is already difficult, in particular for early school leavers and those with no more than a lower-secondary school education (OECD, 2010b). It is even harder for young people with poor mental health.

In general, the state and functioning of the overall labour market have a major influence on whether youth master this transition successfully. For instance, removing demand-side barriers and disincentives for firms to hire inexperienced workers on permanent jobs is particularly important for young people. Likewise, sufficient incentives through, and support by, respective employment authorities such as the public employment service (PES) or municipalities facilitates job-finding and reduces the likelihood of prolonged joblessness. Importantly, the overall economic climate at the time of transition also plays a major role; youth-friendly employment policies are therefore even more important when the economy is weak. The following section analyses the potential of labour market policies to support vulnerable youth.

### *Fewer job opportunities for young Swedes may explain the increase in self-reported health problems*

As seen in Chapter 1, the health complaints of young people in Sweden appear to have increased more than in several other OECD countries. While

there is no simple explanation for this rise, increasing difficulty to enter the labour market has been identified as the biggest factor in several Swedish empirical studies (Lager and Bremberg, 2009; Bremberg *et al.,* 2006). Research following school leavers also confirms that early unemployment among young men and women had significant explanatory power when considering risks of smoking, psychological difficulties/symptoms and—among men only—somatic symptoms, even after controlling for initial health behaviour and socio-economic background[3] (Hammerstrom and Janleret, 2002). At the international level, a convincing body of research also suggests that high unemployment is one of the strongest risk factors affecting mental health status (OECD, 2012a).

The labour-market situation of youth in Sweden has indeed become more problematic in the past decade. At 18.8%, youth unemployment rate was already higher than the OECD average in 2007; it has increased further to 22.9% of the labour force in 2011, while employment rates have fallen from already low levels a decade ago (Table 2.4). At the same time, temporary contracts and part-time work now account for a larger share of youth employment than was previously the case.

Table 2.4. **Indicators for youth aged 16-24, 2000, 2007 and 2011**

| | 2000 | | 2007 | | 2011 | |
|---|---|---|---|---|---|---|
| | Sweden | OECD | Sweden | OECD | Sweden | OECD |
| Employment rate (% of the age group) | 46.7 | 45.5 | 46.8 | 43.2 | 40.4 | 39.5 |
| Unemployment rate (UR) (% of the labour force) | 11.7 | 12.1 | 18.8 | 12.0 | 22.9 | 16.2 |
| Relative UR youth/adult (15-24)/(25-54) | 2.4 | 2.3 | 4.3 | 2.4 | 4.2 | 2.3 |
| Incidence of long-term unemployment (% of unemployment) | 8.9 | 19.9 | 3.6 | 16.5 | 5.4 | 21.3 |
| Incidence of temporary work (% of employment) | 49.5 | 24.3 | 57.3 | 25.6 | 57.5 | 25.3 |
| Incidence of part-time work (% of employment) | 31.8 | 20.8 | 34.7 | 26.8 | 36.6 | 29.3 |

*Source*: *OECD Employment Database, www.oecd.org/employment/database.*

Apart from a cyclical rise in the youth unemployment rate due to the crisis, structural features including very high effective minimum wages and strict employment protection legislation in Sweden have been identified as key obstacles for youth entering the labour market[4] (OECD, 2008a). High wage and non-wage labour costs make it relatively costly for employers to hire inexperienced young people (OECD, 2006). At the same time, strict job protection legislation for permanent contracts leads to weak incentives for employers to hire which, in turn, complicates and prolongs the job-search process for new entrants. Whether due to structural or cyclical factors, vulnerable youth and those with mental health problems with a weak

foothold in the labour market are strongly affected by a lack of employment dynamics as they are likely to find themselves at the end of the hiring queue.

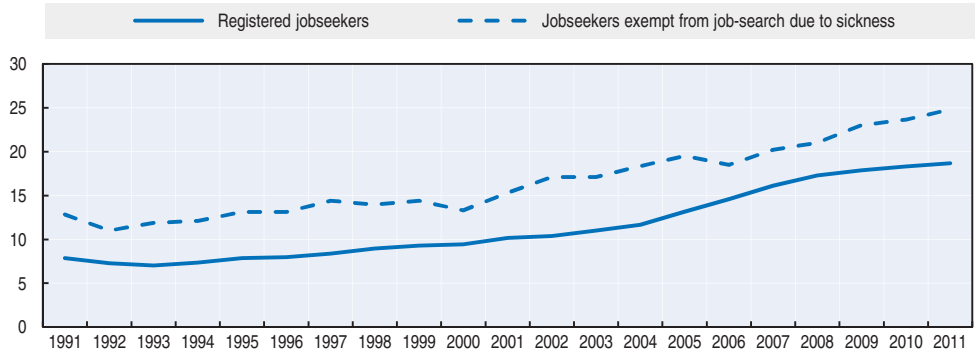
In an effort to increase employment among young adults, the government has embarked on various policy initiatives mainly raising employers' incentives making it cheaper for companies to employ young people. For example, social security contributions for people under the age of 26 have been halved to make it easier for all young people (not just unemployed) to enter the labour market and gain work experience. This has also reduced demand side barriers for young people who have been absent from the labour market due to illness, including those on disability benefit or on sick leave for more than six months.[5]

### *Improving employment support for vulnerable youth*

Administrative data show that the share of mental disorders among registered young jobseekers with a disability and jobseekers exempt from job-search due to sickness is growing at PES offices (Figure 2.6). The "true" prevalence of youth with mental health problems is likely to be higher since many individuals with mild disorders go without being recognised by caseworkers. This calls for systematic interventions for identifying unemployed youth with a higher risk of developing psychological problems.

Figure 2.6. **Mental health problems among jobseekers at the PES are growing**

Share of mental disorder in all health conditions among *i)* registered jobseekers with a disability and *ii)* jobseekers exempt from job-search due to sickness, age 18-30, 1991-2011




*Source*: Administrative data provided by the public employment service (PES).

Currently, unemployed young people aged 16-25 are a priority group at the PES and are assigned to the Youth Job Guarantee scheme after three months (instead of six months which is the qualifying period for those above 25 for the ordinary job guarantee) but there is little focus on identification of

psychological problems. Young jobseekers with a disability, whether physical or mental, follow the same route as other jobseekers and are predominantly placed in mainstream programmes. Although there are advantages of mainstreaming, more targeted programmes for youth with complex needs, early identification and personalised support, is desirable for vulnerable youth.[6] Evidence shows that even the best-performing programmes, often fail to help youth at high risk of labour market and social exclusion, notably youth who cumulate a number of problems including psychosocial and behavioural problems (OECD, 2008b).

Vulnerable youth with a mental disorder are often not considered available for the labour market, and will end up on social assistance benefits. The current arrangement for providing labour market support for young persons who receive social assistance, especially early school leavers, is also problematic. First, because youth in receipt of social welfare are required to register both at the PES and the municipal office, they risk being sent from one agency to another thus creating efficiency loss. Second, evidence suggests that although the PES should offer the Youth Guarantee irrespective of the benefit status, it lacks incentives to do so for unemployed workers aged below 20, as this group does not qualify for unemployment insurance.[7] In other words, vulnerable youth on social assistance have the least access to labour market programmes through the PES. Lack of intervention among this group is a major concern as young people are already overrepresented among receivers of social assistance.[8]

To tackle these problems some municipalities offer services to social assistance recipients and early school leavers through Navigator Centres. These centres provide a good model offering co-ordinated employment, educational and health support for youth facing high entry barriers to the labour market (Box 2.2). However, since municipalities have a lot of discretion when treating young workers, there is no information on how many such Navigator Centres exist nor universal guidelines on how they should operate. Information on the average contents of the labour market programmes they offer is also not fully known. Common features include co-operation between municipal authorities, the public employment service, voluntary organisations and industry with a view to reaching non-traditional solutions.

Evaluations on the success of the navigator centres across the country are not available. But evidence from the pilot phase suggest that out of the 2 000 young people that were involved in the scheme, some 45-70% have, after being placed in a navigator centre, moved on to education, employment or work experience. Qualitative evidence suggests that Navigator Centres are a good way of filling the gap for young people who are sent round between the employment service, social services and the local education committees *www.ungdomsstyrelsen.se/english_art/0,2683,8099,00.html*. Ensuring that all

municipalities offer Navigator Centre type services would ease access to both employment and health support for this group. Alternatively, the Navigator Centre could be turned into a national initiative subject to a rigorous evaluation of the programme.

Box 2.3. **Navigator Centres provide a good model of integrated services for youth**

During 2005-07, the Swedish National Board for Youth Affairs piloted eleven municipal navigator centres, which should include three different actors and have a common "single-door" to provide support for young people.

The centres are aimed at young unemployed people aged 16-25 years. The target group for navigator centres consists of individuals who are harder to motivate than those usually encountered by the employment service. They include young people who suffer, or have suffered, from social phobias, depression or the effects of drug abuse.

Many of the youth involved are on social assistance benefits and have never been integrated into the labour market. Services are mainly provided using a one-stop shop formula. Within this framework, navigator centres provide programmes and services that range from curriculum vitae writing skills, educational and vocational counselling, and motivational interviewing to other activities orientated towards preventative health care. Young people can also be referred to psychological support given by the county level actors in Sweden, or in the centre, depending on the nature of the disorder and organisation of the centre. Young people can be referred through various agencies, including municipal units for employment, the PES and the Social Insurance Agency (SSIA). Participation in measures offered is mandatory if the referral is made by any of these three agencies.

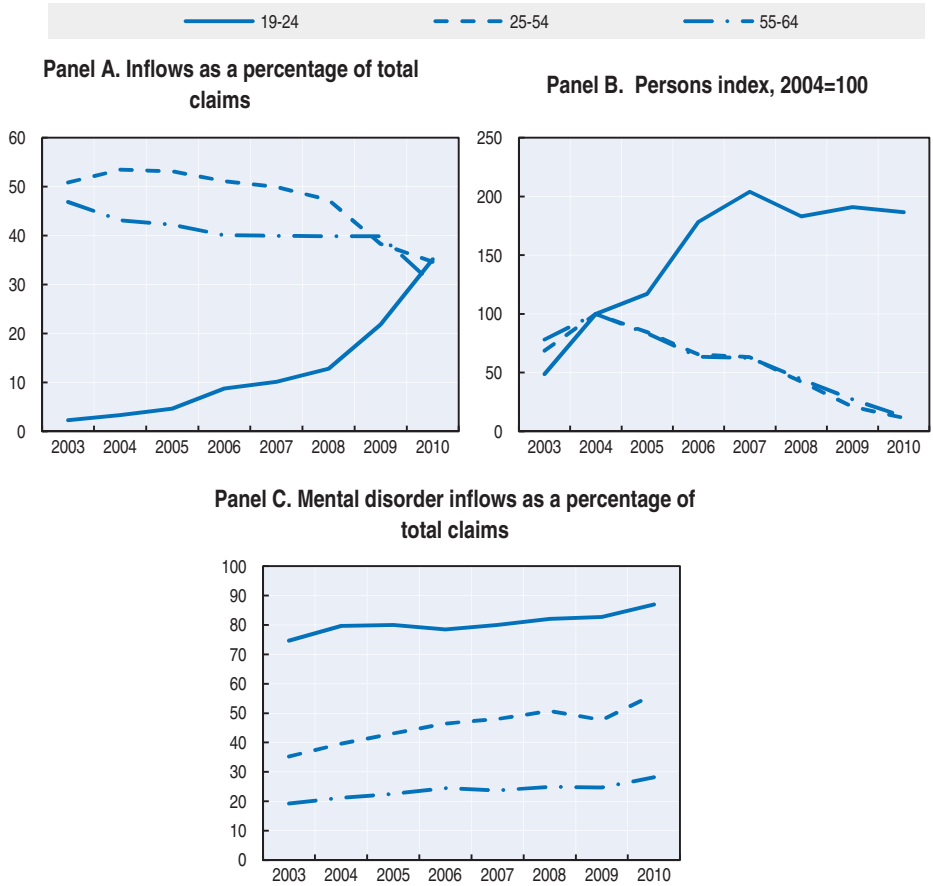
## Tackling the issue of young people on disability benefits

Young adults with mental disorders who fail to make a successful transition into employment often end up on disability benefits (OECD, 2012a). Across OECD countries, young people represent the fastest growing age-group claiming disability benefits. In Sweden, this change is even faster than in most other countries (as seen in Chapter 1). This is a worrying trend, since disability benefits in most cases are still treated as lifelong pensions and those entering such schemes are very likely to never re-enter the labour market.

Figure 2.7 reveals a distressing picture of the recent developments of young people on disability benefits. Panel A shows that today a third of all new disability claimants are in the age group 19-24, compared to only 5% or less a few years ago. Similarly, the absolute number of new disability claims of the older populations has dropped markedly while new claims for young people quadrupled during 2003-10 (Panel B). Finally, mental health conditions accounts for over two-thirds of all disability claims for youth under the age of 25 (Panel C).

Figure 2.7. **Disability benefit trends for youth deviate drastically from the overall trend**

New disability benefit claims due to mental disorders by age, as a share of all claims and in levels




*Note*: Data include mental retardation/intellectual disability, organic mental and unspecified mental disorders.

*Source*: OECD questionnaire on mental health.

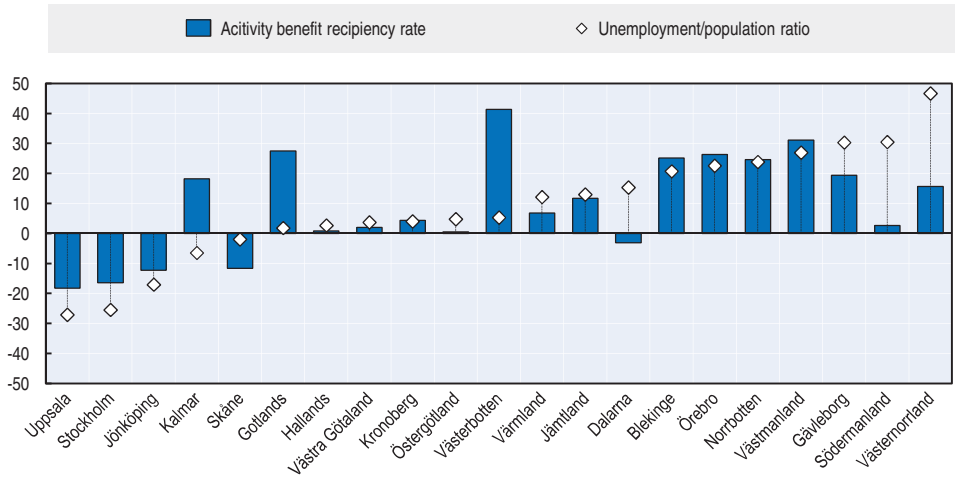
### *Can the labour market explain the rise in activity compensation?*

In Sweden, one reason for the popularity of early transition to disability benefit stems from the fact that it is increasingly difficult for young Swedes to find employment. Indeed, the relationship between disability and youth unemployment gives an interesting picture, especially at the regional level (Figure 2.8). In regions where the labour market is strong, disability beneficiary rates tend to be lower, while in regions where jobs are scarce, disability benefits rates are higher. Although the direction of causality is

difficult to determine, diminishing labour market opportunities and long-term unemployment are considered to be an important risk factor in pushing vulnerable people onto disability benefits (OECD, 2010b).

Figure 2.8. **A strong positive correlation between youth unemployment and disability across Swedish regions**

Differences in percentage from the overall rate in the country




*Note*: Regions ranked by increasing order of the difference in their unemployment/population ratio from the overall country ratio.

*Source*: Swedish Social Insurance Agency and the public employment service (PES).

It is plausible to assume that the disability benefit scheme has been increasingly used to ease the labour market pressures associated with high and ongoing problems in the job market for youth. Moreover, there is evidence showing that periods of unemployment may cause health problems *i.e.* depression and psychological disorders among jobseekers which in turn may affect their ability to work and encourage individuals to seek disability benefits.

## *Screening of pupils entering special schools needs to be improved*

One major challenge confronting many OECD countries is the increasing number of young disability benefit claimants with mental ill-health coming directly from the special school systems (schooling for persons with a disability). This could be attributed to the interaction problems between the education system and the employment and social protection systems, which in many cases leads to young people with

disabilities and mental health problems to "choose" the social protection system due to transitional gaps from one system to another.

Since the reforms to disability benefit for young people in 2003, some commentators argue that in most cases young people seem to be transferring directly from education into the benefit system, as those under the age of 30 can claim a disability pension for prolonged schooling. According to a recent report by the Swedish Social Insurance Inspectorate (ISF), approximately 80% of individuals aged 19 are granted disability pension for prolonged schooling in order to finish elementary or secondary school (ISF, 2012). The report further argues that "there are serious deficiencies, and even legal uncertainties, in the assessments that form the basis of decisions to place a child or young adult in special schools".

In this regard, screening and appropriate assessments of young people moving to special schools are crucial as many of these individuals would move onto disability pension at a later stage. With the new Education Act, the obligation to conduct a thorough investigation before admitting a student for a special needs education has been strengthened. The Education Act now also specifies that an investigation is to be conducted consisting of a psychological, pedagogical, medical and social evaluation of the student. This is an important step in light of the growing issues of mental health problems in young children.

### *Automatic transition of disabled young people leaving upper secondary school without assessing workability*

A certain proportion of young adults who receive disability pension for prolonged schooling have a disability that justifies an early and permanent decision on granting disability pension. However, the current system constitutes a problem for individuals with less severe disabilities, who risk ending up on the disability benefit at an early stage of their lives. Findings from the recent follow-up study by the Social Inspectorate of young people who completed a period of extended schooling demonstrate why change is necessary. The main findings can be summarised as follows:

- A large proportion (around 40%) of those who have concluded the period of Activity Compensation for extended schooling are receiving activity compensation for reduced capacity one year later.
- Many of those who continue to receive activity compensation after the schooling period seem to do it for a long time. This proportion was only reduced by only 2% during the period studied *i.e.* from 43% to 41%, three years later.

- The proportion that has a working income after a period of activity compensation for extended schooling is relatively large. Of those who completed such a period in 2005, almost 30% had a working income four years later. This indicates that within the group there is a fairly large portion of individuals who mange without disability benefits.

In addition, the report points towards "serious deficiencies" in the medical documentation and the assessment process carried out by the SSIA that essentially determines benefit eligibility. Deficiencies are found in the documentation both for individuals who receive disability pension for prolonged schooling and for others, but they are particularly alarming in the former group. Most work capacity instruments do not distinguish between adults and young individuals even though most young individuals have had no or little experience in the labour market. This suggests that most persons are transferred into disability pensions without appropriate assessment of eligibility.

### *Rehabilitation requirements in activity compensation are relatively weak*

Young people on disability pension are obliged to participate in rehabilitation measures and also offered additional activities in which participation is voluntary. There are no specific rules on the type of rehabilitation measures and activities beneficiaries must participate in as long as activities have a positive effect on general performance and lead to or improve work capacities (Honeycutt and Mitra, 2005). Examples of activities include school courses, involvement in sports, exercise programmes, and work training experiences. The extent to which rehabilitation requirements are fulfilled and its effectiveness is questionable. Follow-up of those participating in activity compensation is limited. However, results from a recent follow-up study based on a sample of beneficiaries who received activity compensation in October 2011 can shed some light. According to this, the majority of beneficiaries participate in non-work related measures. Only 19% participated in vocational rehabilitation measures.[9] A striking 60% of all beneficiaries participated in sports measures (SSIA 2012). There are no evaluations on how effective these measures are in moving persons off benefits or helping them to return to work. Nevertheless, it is plausible to assume that a lack of participation in vocational measures is likely to weaken the effectiveness of rehabilitation measures supporting young people back into work.

## Conclusion and recommendations

With almost one in five Swedish children aged 10-18 years suffering from a mental disorder, actions to tackle mental health problems in schools are a major priority. Recent government efforts to promote mental health in schools, *e.g.* mandating all schools to hire psychologists, go in the right direction but are likely to be insufficient to deal with the large-scale problems confronted by schools. This is problematic as mental health problems increase the risk of school drop-outs; lower chances of entering the labour market; and increase the probability of moving onto disability benefits. Mental health services need to be integrated within the school environment so that school personnel view mental health services as an integral part of the education system.

Beyond, educational policies, active labour market programmes are needed for young persons, in particular for school drop-outs and the NEET group. The following recommendations should be considered in order to improve services in schools and ensure smoother transition into the labour market, in particular for youth at a high risk of developing mental disorders such as those among the NEET group.

### *Improve early intervention and access to support in schools*

- *Increase resources at the school to ensure rapid access to psychologists*. The school health and welfare services need to devote far more resources to tackle the large number of children and adolescents who experience mental health problems in schools. Current waiting time to see a school psychologist should be reduced.
- *Provide systematic guidelines to staff in school health services*. All municipalities should provide guidelines to social workers and school health nurses on: *i)* identification of mental health problems; and *ii)* guidance on how to respond to pupils' needs (*e.g.* when to refer to school psychologists and or refer pupils to external support units, such as psychiatric services or youth clinics). An obligation for providing guidelines should be laid down in the Education Act and implementation should be followed-up systematically.
- *Increase competence amongst teachers about psychiatric disorders.* Teachers have direct day-to-day contact with their pupils and, thus potentially have a good knowledge of pupil problems. Teachers should be given adequate training in order to spot early signs of mental health problems and to understand various risk factors associated with it. This could be achieved by including a mental health component in the teacher curriculum.

### *Carefully monitor early school leavers and the NEET and co-ordinate their employment support*

- *Youth Clinics can play a central part in providing services to pupils with common mental health problems*. NEET are at a much higher risk of not receiving mental health treatment due to their lack of contact with various authorities. Youth Clinics provide an ideal opportunity to target this group given their substantive contact with Sweden's young population. To better target and strengthen services of youth clinics several actions would be desirable: *i)* screening of mental health for all youth; *ii)* having sufficiently resourced youth clinics all across Sweden to provide low-threshold health intervention and refer to specialist psychiatric services when necessary; and *iii)* ensuring good outreach with schools , local services and PES services.

- *Consider setting-up a "youth agency" in order to systematically identify and support young people in the NEET group*. To cope with the problem that many young people in the NEET group are not known to the PES or at the local level, a few OECD countries (*e.g.* Denmark, the United Kingdom, Belgium, Norway and Luxembourg) have created ad hoc agencies. These so-called "youth agencies" are designed to support young people specifically in their study and career orientation. One option would be to extend the role of Navigator Centres to reach out to young people already before they leave school and during their educational and vocational programmes. In municipalities, where this may already occur, programmes and procedures should be evaluated properly.

- *Ensure that all municipalities offer co-ordinated services like the Navigator centres*. Navigator centres create a common ground of co-operation for different actors including local municipalities, the PES and the education sector. This would ease access to labour market programmes and other support required for disadvantaged youth.

- *Make sure that the PES offers the Youth Guarantee scheme rigorously to everyone, irrespective of the benefit status.* This would help facilitate early intervention for the most vulnerable and help to eliminate inefficiencies that occur by shifting social assistance recipients between two systems.

### *Curtail the inflow into disability benefit*

- *Abolish granting activity compensation for prolonged schooling.* Evidence suggests that there are large differences in the ability to participate in the labour market within the group that is transferred to disability. To break this pattern, consideration should be given to paying youth with disability in special schools a study grant and removing the automatic entitlement to disability benefits.
- *Adopt a more active approach with greater focus on employment measures.* This would remove disincentives arising from the current disability system and better prepare persons who have remaining capacity to work for the labour market. Other OECD countries have already embarked on this route. For example in the Netherlands, the special disability benefit for young people now has a strong work-orientated approach including an obligation to accept work or an education offer at the age of 27. In Denmark, a new disability benefit for those under the age of 40 is to come into force from January 2013 known as the "rehabilitation model" with a greater focus on rehabilitation and integration of services involving both the health sector and the labour market institutions.

## *Notes*

1. One factor behind the variation in incidence of mental health problems among girls and boys might be greater expectations on girls' school performance. For example, according to the Living Conditions Survey of Children 2010, a much higher proportion of girls (64%) than boys (39%) report stress due to high demands on themselves, and stress due to homework and school tests (73% and 50% respectively). Studies from other countries have also shown school performance to have a great impact on girls' mental health (Sweeting and West, 2003). Other relevant factors may include pressures linked to a growing focus on personal appearance and disparities in coping strategies between girls and boys (*Swedish Public Health Report*, 2012).
2. About half of the school social workers and psychologists are employed in other organisations than school itself.
3. The cohort of school leavers were 16 years at the beginning of the study and were followed until the age of 30 irrespective of their trajectories after completing compulsory schooling (future studies, work, etc.).
4. There is no formal legislated minimum wage in Sweden but collective agreements specify minimum wages for employees in different sectors.

5. In the *New Start Jobs* scheme, employer's labour costs are lowered by 40% for a period of one year for hiring a person below the age of 26. According to a recent evaluation, 68% of all people below the age of 25 had entered employment 90 days after they completed a New-Start-Job and this is seen as an "effective door-opener into the labour market" (*www.eurofound.europa.eu/emcc/erm/studies/tn1109042s/tn1109042s_3.htm*).

6. According to Greve (2009), there is a clear tension between mainstreaming and targeted policy intervention. It is argued that in cases where disability issues are mainstreamed, there is a risk of reduction in specific interventions. To ensure adequate support, specific targeted measures should therefore compliment mainstream programmes.

7. According to a follow-up study of young people not in education and employment, a higher proportion of young people between the ages of 16 and 19 were receiving some form of municipal support compared with those participating in a national labour market measure in 2007. The reverse applied to young people between the ages of 20 and 25 since they qualify for unemployment insurance (Ungdomsstyrelsen, 2011).

8. Of the total number of social assistance recipients, aged 18 to 64, around 40%, equivalent to approximately 119 000 persons, were aged between 18 to 29 (NBHW, 2011).

9. In this category, the most popular measure was work trials or work training followed by preparatory training for work and education.

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# *Chapter 3*

# Productivity, sustained competitiveness and the Swedish work environment

*This chapter looks at the role of employers who are ideally placed to help people already in the workforce to deal with mental health problems and retain their jobs. It first discusses the impact of psychosocial work environment factors on stress and mental health and various workplace practices aimed at preventing mental health problems from arising in the first place. It then looks at job retention responses by employers; additional needs of employers in this regard; and gaps in service provision. Finally, it reviews employer incentives to prevent sickness absence more generally and provision of special support for those with a mental disorder returning to work after a period of sickness absence. The chapter also pays attention to the role of stigma and the potential impact of employment protection legislation on hiring persons with a mental disorder.*

Neglecting mental health problems at the workplace is not an option. As shown in Chapter 1, more than 60% of Swedish persons of working age with a mental health problem are in employment. Utilising the workplace as a setting for promoting good mental health is therefore critical in protecting the mental (and physical) well-being of the workforce, but also improving employee productivity and thereby supporting economic competitiveness.

Addressing poor working conditions, high levels of stigma associated with mental illness and lack of knowledge of mental disorders at workplaces would be necessary to minimise the risk of job loss and reduced productivity at the workplace. Swedish policy addresses these issues with increasing focus in the past decade on the psychosocial working environment. But as in other OECD countries, practical management and implementation remains a challenge for most workplaces.

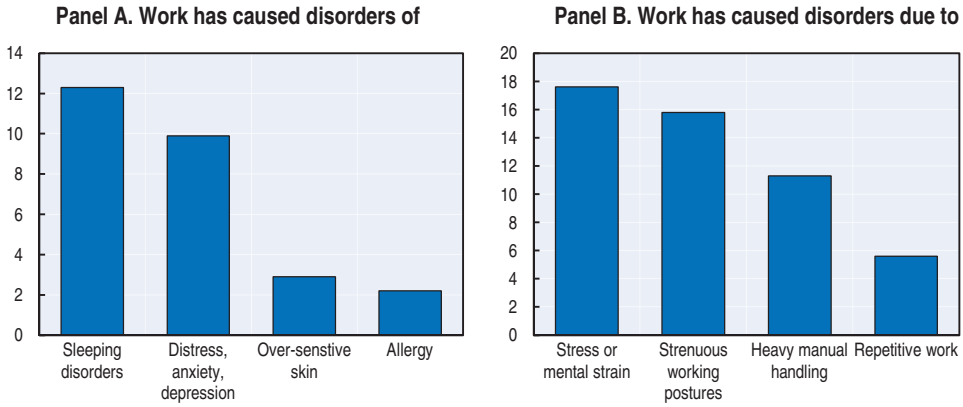
## Mental health problems at work

### *Psychological disorders are the most frequent work-related disorders*

According to the Work Environment Survey, sleep disorders, distress, anxiety and depression are the most frequent work-related disorders reported by Swedish employees. Around one in five workers report to suffer either from a sleeping disorder or anxiety and depression (Figure 3.1, Panel A).

Figure 3.1. **Stress and mental strain are the most common cause of work-related disorders**

Work-related disorders as a percentage of the employed population, 2010




*Source*: Work-related Disorders 2010, *Arbetsmiljöstatistik Rapport 2010:4*.

At the same time, stress and mental strain are the most common cause of work- related disorders after strenuous working postures. About 18% of workers reported that "work has caused disorders because of stress or mental strain". Among women, the most frequent cause of work-related disorders is mental strain while strenuous working posture is the main cause for men. The shift to stress and mental strain as main causes of work-related disorders can be partly explained by the change in the workforce composition where more and more persons work in the service sector.

### *Mental ill-health is associated with psychosocial work environment factors*

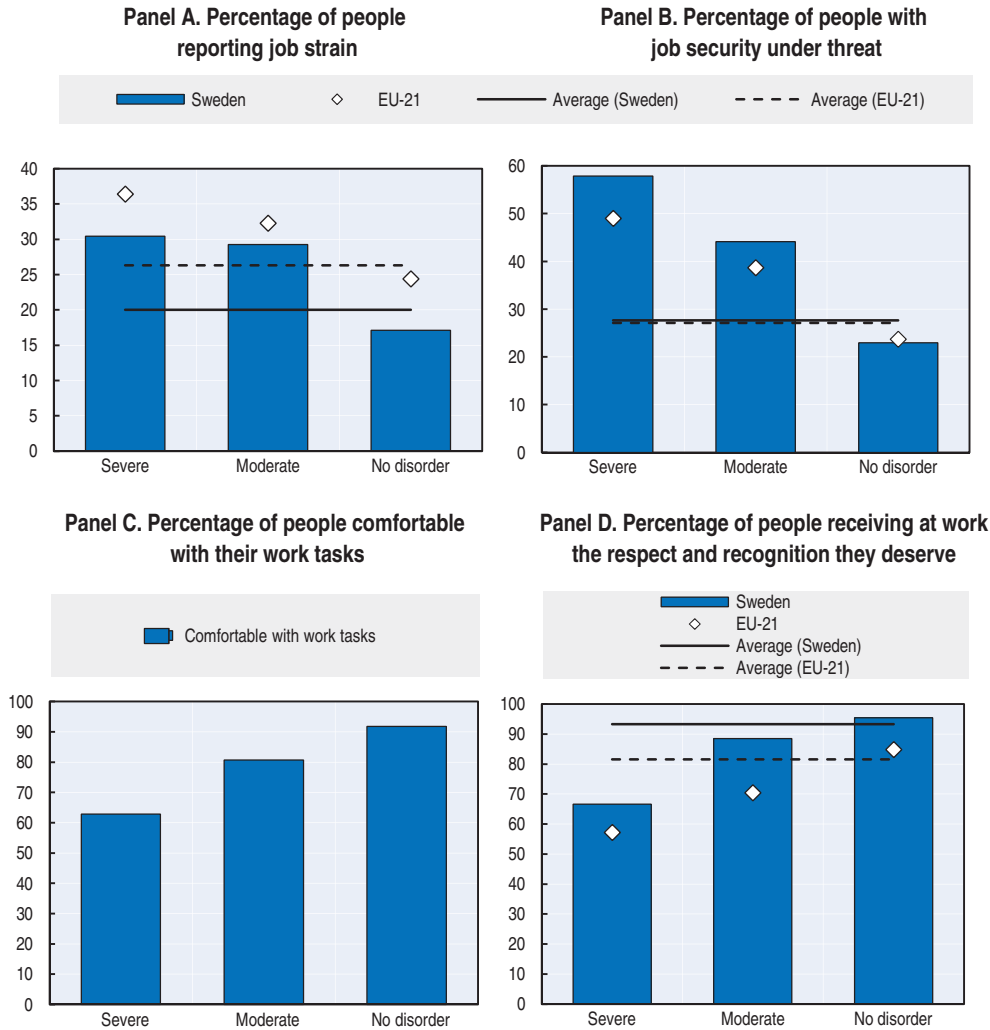
There is now compelling evidence to show that employment is better for mental health. But the quality of work is also important. Poor quality jobs or a psychologically unhealthy work climate can erode mental health and trigger sickness absence or push people into unemployment and poverty.

OECD (2012) concluded that workers with a mental disorder tend to work in jobs of poorer quality; and are more likely to experience high job strain *i.e.* have high job demands and low influence at work and therefore are at a higher risk of developing mental disorders and having lower job satisfaction. What working conditions are Swedish workers facing?

Data for Sweden confirm these findings although, by and large, working conditions seem to be superior to those in many other countries. Like elsewhere, people with a mental disorder are much more likely to report job strain – with an almost 15 percentage-point difference between workers with a severe and no mental disorder (Figure 3.2, Panel A). However, the overall level of job strain (for all workers) is much lower than on average across 21 European countries. Furthermore, workers with a mental disorder report job insecurity much more often. Perceived job insecurity is higher than on average in OECD countries (Panel B). Furthermore, workers with a mental disorder are less likely to receive the recognition they deserve, with large differences by degree of severity of the mental disorder (Panel D), and are less likely to be comfortable in their work tasks (Panel C).

Figure 3.2. **Workers with a mental disorder work in jobs of slightly poorer quality**

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




*Note*: Results are based on all countries covered in the respective surveys.

*Source*: OECD calculations based on Eurobarometer 2010, for Panels A, B and D, and the National Health Interview Survey 2009/11 for Panel C.

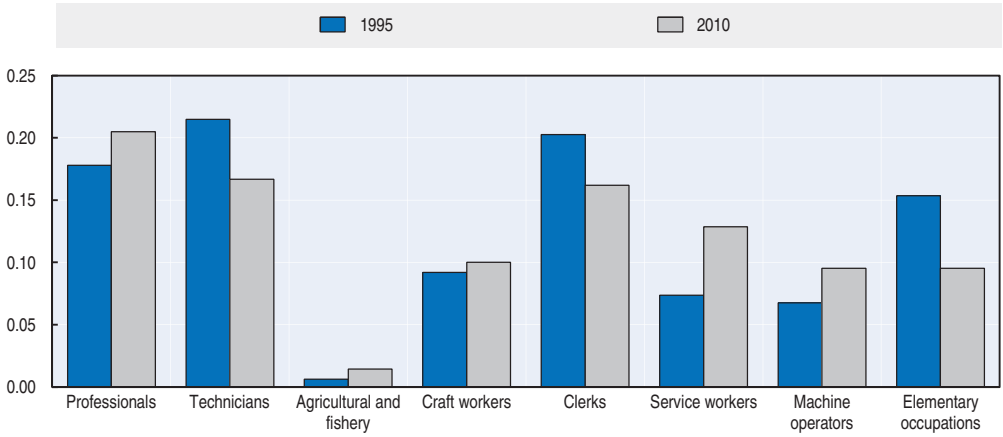
## *Occupations most at risk*

Despite superior working conditions compared with other countries, not all workers enjoy high well-being or a healthy working environment. Job strain

*(used as a proxy for various psychosocial factors)* varies markedly across different occupational groups. Among the different occupations, job strain has increased among machine operators, professionals and employees working in the service sector (Figure 3.3). The latter two categories include professions such as teachers, doctors, nurses, psychologists and social workers who may be more susceptible to high-level stress or job strain as they have frequent encounters with difficult customers, pupils and patients. A recent report from Sweden confirms these findings as it reveals that a greater proportion of employees in the health sector report poor working conditions, unhealthy habits and poor health (Swedish National Institute of Public Health, 2011).

Figure 3.3. **Job strain has increased among professional and service workers in Sweden**

Proportion of workers exposed to job strain, by occupation, 2010



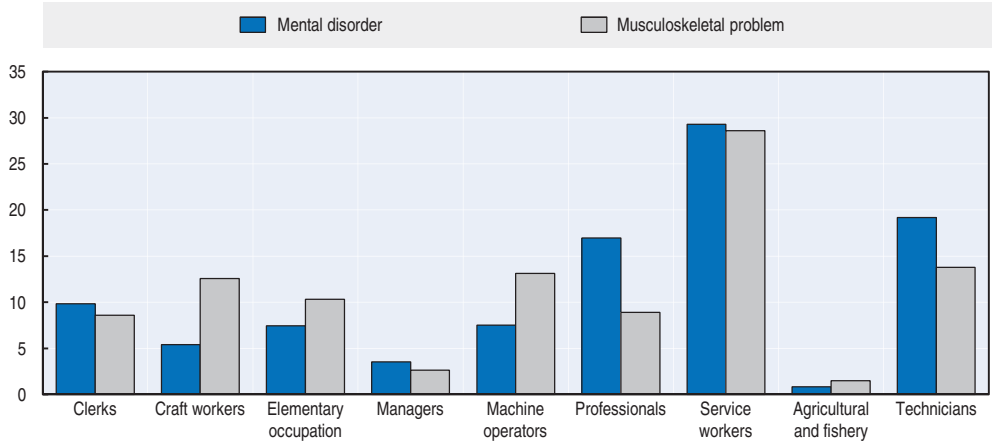

*Source*: OECD calculations based on European Working Condition Survey, 2010.

Job strain is strongly linked with mental ill-health as well as sickness absence. Consequently, inflows into sickness benefits are highest among employees experiencing high levels of job strain. Mental health problems are the most important cause of absence from work among employees in professional, technical and service sector jobs albeit the difference between mental and physical problems are marginal in the latter category (Figure 3.4).

The prevailing levels of psychological disorders and high strain among Swedish employees point towards the need for systematic action at workplaces. A two pronged strategy is needed to address challenges in the psychosocial working environment: prevention strategies, which have developed in Sweden within the field of health and safety at work; and early intervention at work for those facing problems already, to prevent exclusion from the labour market.

Figure 3.4. **Occupation-specific causes of sickness reflect higher job strain in those occupations**

Inflows into sickness benefit by occupation and health condition as a percentage of total inflows into sickness benefit for each condition, 2008




*Source*: Data provided by the Social Insurance Agency (SSIA).

## Prevention strategies

### *Prevention of stress, job strain and mental health problems*

According to the Working Environment Act (executed by the Swedish Working Environment Authority[1] – WEA), every company is required to monitor the health and safety of their workers as "a natural part of their daily work" and conduct a systematic assessment of working environment (*known as Systematiskt arbetsmiljöarbete* – SAM). This duty extends to ensuring workers' mental as well as physical health and safety.

Preventive action regarding work-related stress is carried out in accordance with SAM. Among other guidelines, SAM stipulates identification and assessment of psychosocial risks and to facilitate these obligations, the WEA offers an extensive range of tools and check-lists. Examples include, monitoring workload; shift work, job content, job pace and conflict between colleagues. According to a recent European survey on managing safety and health at work, Sweden topped the charts when it came to dealing with psychosocial risks (ESENER, 2010). For instance, Sweden had one of the highest prevalence of establishments with "procedures" [2] in place on work-related stress, bullying and harassment.

Despite this success, the Working Environment Act has its shortcomings. For example, small-scale enterprises (SSE) face difficulties in fulfilling regulations in relation to the Working Environment Act. This is an important policy issue since more than 98% of all private enterprises are SSEs (<50 employees) and about one million people, 35% of all employees in Sweden, work in such enterprises. Evidence suggests that SSEs in particular, lack knowledge on risk factors at work; their assessment and prevention in the work environment (Gunnarsson *et al.,* 2010). Better support and supervision could lead to improvements in the fulfilment of the demands.

Another potentially problematic issue is the lack of focus on mental disorders directly. For instance, evidence shows that having a mental disorder itself is one of the biggest factors of sickness absence, more critical than other risk factors such as job insecurity and intensity of work (OECD, 2011). Whilst focussing on adapting organisational structure and the work environment may help to minimise undue levels of stress, it may not be sufficient for employees already suffering from a mental disorder. This implies that employers should also invest in tools that help to identify mental health disorders explicitly. Without systematic identification, mental health problems at work are bound to be left unnoticed and untreated and result in high sickness absence and hinder productivity. In this context, WEA should also seek ways to address mental health problems *e.g.* either through surveys and questionnaires in order for employers to be able to offer timely support.

Similarly, recommendations by the WEA on handling workers experiencing psychological distress focus merely on changing employees' work circumstances. These include shortened or flexible hours, courses in stress management, variation in duties, individual tutoring, etc. The WEA ought to also provide adequate guidelines for employers on how and when to suggest employees to seek treatment for their disorder. This, in turn, requires building strong links with general practitioners (GPs) and other health services.

Overall, the current government has started to take further action to improve the psychosocial work environment but more concrete efforts should be made to tackle the challenges highlighted above. In 2010, the government announced a national action plan for the work environment (the first of its kind in Sweden) to shape the working environment for the next five years. The WEA is ultimately responsible for the execution of the action plan and is given additional funding for developing and implementing initiatives. So far, a number of concrete activities have been initiated. Ongoing areas of special focus include; improving working environment conditions for women as they are over-represented among employees suffering from stress and mental strain; increased inspections of workplaces

and building knowledge of the psychosocial risk factors at the workplace. Around thirty national seminars have been held and several publications are made available from the WEA website on this topic to increase knowledge among employers and employees. Although these policies are a step in the right direction, the WEA should ensure that such efforts reach small enterprises that may need greater support in better managing and understanding mental health problems.

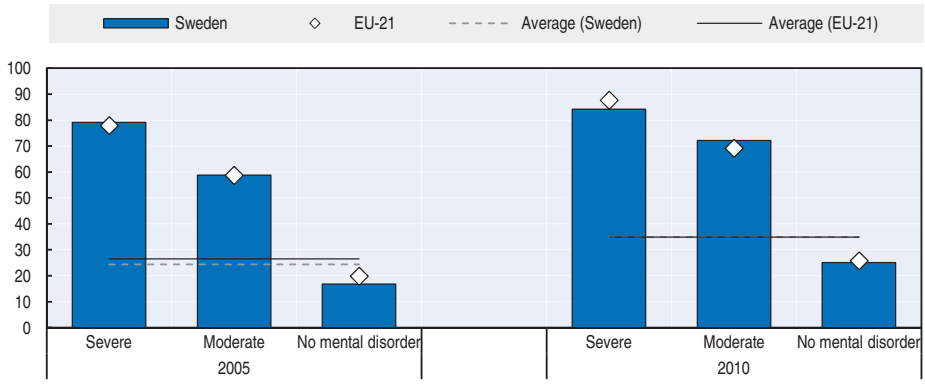
## Retention strategies

### *Restoring employee and employer competitiveness*

In parallel to securing good working conditions, having tools to manage mental health issues when they arise – be they caused by, related to or not to work – are critical to minimise adverse implications on workers' performance. As illustrated in Chapter 1, reduced productivity because of a health problem is very widespread, and especially so among workers with a mental disorder. Not only is the proportion of workers reporting health-related performance issues high but it has increased among all workers in both Sweden and on average across OECD countries, and most so among workers with a moderate mental disorder.

Figure 3.5. **Productivity losses have increased more among persons with mental disorders**

Percentage of workers who were not absent in the past four weeks but who accomplished less than they would like as a result of either an emotional or a physical health problem, in Sweden and average over 21 European OECD countries, 2005 and 2010




*Source*: OECD calculations based on Eurobarometer, 2005/6 and 2010.

This suggests an increasing number of workers with a mental disorder struggle at work, with problems that reduce performance and output but do not lead to the worker being off sick. Supporting these workers struggling at work can yield economic benefits for the business or organisation, in terms

of increased commitment and job satisfaction, staff retention, improved productivity and performance.

### *Occupational health services*

Occupational health services (OHS) can play a critical role in ensuring high levels of health and well-being among workers, retain those who are struggling at work and help those who are returning to work after sick leave. OHS in Sweden primarily concerned with job modification and rehabilitation of those who have become ill. Occasionally, OHS conduct psychosocial risk assessments and participate in major organisational change processes which may have an impact on the working environment.

OHS, however, are not mandatory. Around, three in four Swedish employees have access to OHS in some form, but the range of services offered varies a lot depending on what is purchased by the employer. There are some concerns over the quality and the provision of OHS as the former public financial support ceased in 1992, and purchasing of OHS is now left to the employer's discretion. Since 2010 the Swedish Government, through the Social Insurance Agency, offers financial support for curative services if OHS's provide measures to promote return to work for sick-listed employees.

Available evidence on the extent to which OHS deal directly with employees with mental health disorders is mixed. For example, where occupational health services exist, whether in-house or contracted-out, evidence suggests that they are likely to have some competence to deal with individuals with mental health problems. Sweden is the country that most frequently uses help of psychologists (ESENER, 2010).

The OHS also utilises a range of methods to support employees who are having problems at work. Table 3.1 illustrates these measures. Of the six measures investigated, provision of training (61%) is the most frequently reported, followed at some distance by changes in work organisation (52%), redesign of the work area (38%), confidential counselling (44%), changes to working time arrangements (39%) and finally, set-up of a conflict resolution procedure (37%).

Measures are also more widely adopted in Swedish establishments compared to the average in European countries. Relatively frequent confidential counselling and set-up of conflict resolution procedures are likely to help those with mental health disorders. Anecdotal evidence from various countries has shown that persons with mental health problems tend to resort to sickness benefits due to conflict at work which requires more personal support rather than a mere change in immediate work tasks. However, little is known on the impact of these different measures on factors such as job retention.

Table 3.1. **OHS in Sweden offer a wider array of measures than in other countries**

Measures by OHS to deal with psychosocial risks in the last three years, in percentage of establishments

| | Sweden | EU-27 average |
|---|---|---|
| Provision of training | 61 | 58 |
| Changes to the way work is organised | 52 | 40 |
| A redisgn of the work area | 38 | 37 |
| Cofidential counselling for employees | 44 | 34 |
| Changes to working time arrangements | 39 | 29 |
| Set-up of a conflict resolution procedure | 37 | 23 |

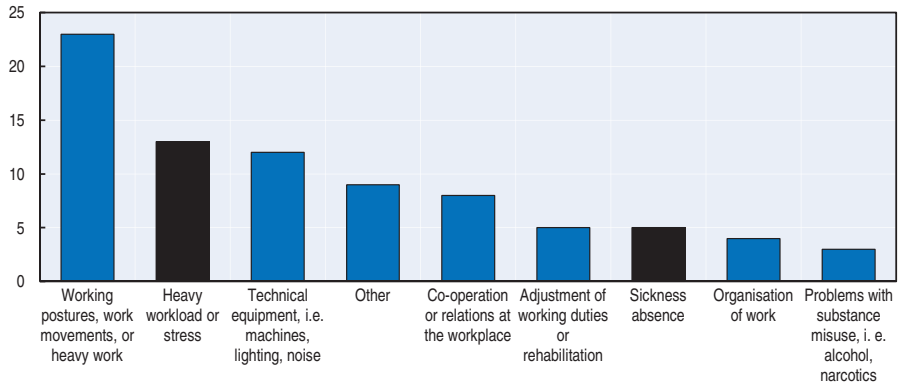
OHS: Occupational health services.

*Source*: European Risk Observatory Report, European Agency for Safety and Health at Work.

In spite of having good work procedures and a well-resourced service, data shows that OHS still do not address mental health concerns adequately. Among the assessments carried out by OHS in Sweden in 2010, around 23% were related with working postures and/or heavy work, while only around 14% were related to workload or stress. Moreover, despite the recent initiative to fund OHS if they increase efforts to monitor sickness absence, fewer than 5% of the assessments looked into sickness absence issues (Figure 3.6). To ensure that OHS give enough attention to mental health problems, awareness of mental ill-health at work should be further raised.

Figure 3.6. **Assessments by the OHS do not reflect the dominance of stress-related work problems**

Assessments by Occupational Health Services, by type of area




OHS: Occupational health services.

*Source*: Work Environment Survey, 2009.

How to fill the gap in the provision of occupational health services, particularly for employees working in small and medium-sized workplaces is a difficult challenge for many countries and available evidence on various policies in this area limited. However, a recent policy initiative in the United Kingdom, Fit for Work Services[3] targeting small to medium employers to address mental health problems of employees and well-being at the workplaces shows promising results. Evidence so far suggests that 74% of absentees who joined one of the pilots in the first year were back at work by the end of March 2011 (DWP, 2012). Such a scheme could also be envisaged in Sweden.

### *Role of employee representatives and managers*

Employees struggling at work can also turn to occupational representatives who can help when it comes to dealing with work-related stress or conflict at work. Having occupational representatives in companies can be an important advantage. Barriers in raising issues related to psychosocial risks, such as stress or bullying with a line manager or higher management, often tend to be higher than those related to traditional risks such as work accidents. This is particularly the case with persons with mental health problems who are at a greater threat of being either dismissed or afraid of disclosing their illness. Notably, there is no research available on how effective occupational representatives are in tackling psychosocial work problems.

Any retention or returns to work process is bound to fail if not fully supported by managers and supervisors. As in other OECD countries, managers do not have the appropriate training and knowledge to deal with psychosocial problems at work. According to a recent European report, stigma and lack of knowledge of mental health problems are the biggest barriers to managing mental health issues at workplaces. In Sweden, around 60% of employers reported "the sensitivity of psychosocial risks" as the most difficult factor, followed by lack of awareness (53%) and lack of training and expertise (51%) (ESENER, 2010). Current support to managers and supervisors on how to handle mental health problems at the workplace is limited. A recent initiative led by the National Board of Health and Welfare aims to support managers through a web-based guidance portal to implement national guidelines for schizophrenia or schizophrenia-like illnesses among employees. These guidelines, however, are inadequate to deal with milder disorders which are much more prevalent at the workplace. Guidance to managers on conditions such as depression and anxiety would be desirable.

### *Support for those on sick-leave*

Job retention is only one side of the coin. The other side is to facilitate a swift return to work for employees absent from work due to sickness and avoid transfers to long-term sickness and disability benefits. As pointed out in Chapter 1, long-term sickness absence has been a key driver of labour market exclusion in Sweden. Accordingly, over the last decade, extensive changes have been made to employers' obligations to improve the work environment and RTW interventions to curtail high sickness absence rates. Financial incentives for employers have been a key area of reforms during this period. For instance, the sick pay period at the beginning of the sick leave spell to be paid by the employer has been revised six times since 1992 (Lidwall and Marklund, 2010). At present, employers only pay the costs of the first two weeks of absence at 80% of wages, following a waiting period of one day. By international standards, the two-week period of employer-provided sick-pay is relatively short.

Under the Working Environment Act, employers are obliged to make occupational adjustments; look after employees rehabilitation needs and oversee the possibility of redeployment to help employees return to work after a period of illness. Also, employment protection continues to be very strong in the case of sickness. Only when an employer can demonstrate that all possibilities of accommodating the sick worker have been explored, negotiations to terminate the employment contract can commence with the involvement of the trade union.

Despite a strong legal framework, there are concerns that in the latest reforms (between 2008 and 2010), financial incentives and employer obligations to adapt work and workplaces have become weaker. Instead, the reduced obligations for employers have been implemented hand-in-hand with increased responsibility for the individual. For example, the employer is no longer responsible to report to the SSIA about what they did to retain the sick worker. Instead, from 2008 it became the responsibility of the employee to get such a report from the employer, if requested by the SIA. Nevertheless, employers can be fined should they refuse to provide such a report. Employers are also no longer responsible for undertaking a formal "rehabilitation investigation" that fed into a "rehabilitation plan" prepared by the SSIA for sick workers. In addition, the new government also abolished the employer co-payment to long-term sickness benefit which was only introduced a few years ago.[4]

Overall, the current Swedish situation is characterised by a strong legal framework coupled with an absence of hard financial incentives. The reduced financial responsibility of employers combined with lacking robust monitoring of employer duties to adjust the workplace may result in weaker

employer efforts in retaining workers. Stronger incentives on employers will be critical to ensure that people returning to their previous jobs do not revert back to sickness benefits. This is particularly important for people with mental disorders for whom the cause of sickness is arising from, or related to, their workplaces; these workers can easily fall back on the sickness system as they can quickly (after three months of employment) re-qualify for a new sickness spell.

Co-operation between SSIA and employers during the sick leave process is yet another problem. Recent evaluations of co-operation during the sick leave process reveal a lack of set procedures for handling contacts between employers and employees during periods of sick leave. Contacts are often *ad hoc* and their nature and frequency is determined by the commitment of the parties concerned. Significant problems remain for small and micro enterprises that have fewer resources to facilitate early return to work for employees who have been on sick leave. For example, a recent qualitative study among employers in micro enterprises showed that, due to the economy of scale, it is not financially viable for them to keep employees who cannot return to their initial work assignments (ISF report, 2012). SSIA would need to provide adequate support to these employers.

### *Encouraging hiring of persons with mental health problems*

Promoting the hiring of persons with mental disorders is a challenging issue confronting policy makers. One of the biggest barriers in hiring persons with a mental disorder is the attached stigma that comes with mental illness. Across OECD countries, stigma towards workers and job applicants with mental disorder is pervasive, caused by a lack of knowledge on the side of employers and fears about having a worker with mental illness in the team, including fears about the consequences on other workers. Dealing with stigma associated with mental disorders at workplaces is critical.

Recognising the pervasive stigma towards mental health problems, a national campaign involving a network of ambassadors who have experienced mental illness themselves was launched in Sweden between 2010 and 2011 to raise public awareness and improve attitudes towards mental illness. The campaign has borne fruit, generating a positive impact on raising awareness of mental health issues (Handisam, 2012).

A second potentially important hiring restriction in Sweden is the seniority or "last in-first out" dismissal rule. International evidence shows that strict EPL like in Sweden tends to reduce employment and participation rates, in particular for people that are subject to entry problems (OECD, 2006). As such, this is also likely to hamper employment prospects of persons with mental health problems as they are more likely to be on

temporary jobs and more likely to have frequent job changes. Job prospects for disadvantaged groups, including workers with mental illness, are likely to be raised if employment protection legislation rules were eased.

Furthermore, strict EPL risks locking people into less-suitable jobs and reduces job mobility. Such risks are even higher for persons with mental health problems as it may make sick people more reluctant to change jobs, which in some cases might help tackle the root cause of their illness in the first place. According to a study conducted by the Swedish Confederation of Professional Employees, the primary reason for employees not quitting their jobs despite being dissatisfied with their work is the risk of losing their current position in the order of selection in the event of a redundancy *www.eurofound.europa.eu/ewco/2009/08/SE0908039I.html.*

## Conclusion and recommendations

In Sweden, working conditions in general are superior in Sweden compared with other OECD countries. Yet, for many employees work-related stress and strain continue to be a main cause for psychological disorders. Job strain is particularly high among employees working in service sector jobs and so is the corresponding inflow into sickness benefit.

Employers are best placed to intervene at an early stage, picking up signals that could lead to psychological distress. However, evidence indicates that current measures are deficient in combating mental health problems at work. Most interventions on work-related stress fall solely under the general framework provided by the Working Environment Act which is not sufficient to subdue risk factors. Provisions of services are also lacking to retain workers who are struggling at work. For instance, OHS still tend to focus on conventional workplace problems potentially leading to physical illness. Similarly, employer incentives to support those who return to work after a period on sickness or disability benefit have weakened in light of new sickness reforms.

At the same time, more attention needs to be given to small companies that lack competence and resources in dealing with mental health problems at the workplace.

### *Preventing and identifying mental health risks and problems at work*

- *Systematic screening of mental health risks at the workplace to offer timely support*. Introduce a risk assessment tool of the psychosocial work environment by the employer, which ought to be implemented rigorously, and monitored. Compliance should be monitored and

followed-up by the Working Environment Authority and non-compliance sanctioned.

- *Raise awareness among line managers about mild to moderate mental disorders*. Current guidelines issued by NBHW for mangers to help identify more severe disorders at work should be extended to recognising moderate disorders.

### *Intervening quickly and adequately when health problems arise*

- *Improve the role of occupational health services to support employees struggling at work*. Issue clear guidelines to OHS to focus on mental health issues at work as well as sickness absence matters more generally. Interventions by OHS in turn should be delivered by multidisciplinary teams including psychologist, RTW specialists and physicians.
- *Provide support to small to medium enterprises.* Easily accessible support to small companies would be key to address mental health issues and resulting workplace matters early on. An independent OHS like the Fit for Work Services in the United Kingdom could be envisaged to help people in the early stages of sickness absence to return to, and remain in, work more quickly after commencement of an illness or when they develop a health condition or impairment. Such a service can be co-financed by small enterprises and the SIA.
- *Strengthen employer obligations to monitor sickness absence and provide adequate rehabilitation for persons on sick leave.* This can be achieved either through soft incentives such obligatory meetings between the employer, the employee and the SSIA whereby actions of both employees and employers can be monitored. If collaboration fails, consider increasing financial incentives *e.g.* by re-introducing sickness benefit co-payments by employers.

## *Notes*

1. The Authority's overarching task is to reduce the risks of ill-health and accidents at work and to improve the working environment in a holistic perspective, *e.g.* physically and psychologically as well as socially and organisationally.

2. Procedures can be considered as a more "formal" or systematic way of dealing with risk, whereas the individual measures may be regarded as more *ad hoc* or reactive in nature.

3. Fit for Work Services offer a free comprehensive one-to-one service to employees to cope with health problems at work, including workers who are at risk of being absent, have been absent from work due to sickness, or are at risk of job loss. The main gist of the programme is to quickly assess client's health and other barriers to work including assisting individuals and support them back to work with the support of a dedicated case manager. Clients may also then be referred to other services such as treatment to address their mental health needs or other relevant services to assist with issues such as debt and housing.

4. In 2006, employers financed the first 14 days of sickness absence and 15% afterwards, and were required to prepare a rehabilitation investigation.

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# *Chapter 4*

# Facilitating early return to work in Sweden

*This chapter discusses how the current welfare system caters for persons with mental health problems and especially, whether the various measures and support the system offers ensure both a speedy return to work and adequate income security. It pays particular attention to the outcomes of recent sickness reforms for different population groups, namely those with a mental disorder and discusses the potential challenges still remaining despite the comprehensive reform. It also addresses the challenges facing caseworkers and general practitioners in assessing mental disorders and granting benefits on the grounds of mental ill-health. It focuses on the role of the public employment service and municipalities and the tools they have to deal with mental illness among the unemployed and social assistance recipients. Finally, the chapter examines the effectiveness of active labour market programmes to promote employment among those with mental disorders.*

Over the past few years, Sweden has reformed its sickness and disability benefit schemes to facilitate early return to work and combat high benefit dependency. Whether the new structure will prove to function for those suffering from a mental disorder remains to be seen. At the same time, mental ill-health represents a growing concern for the unemployment and social assistance systems. The lack of action for the unemployed experiencing a mental disorder is likely to prolong job-search and increase the risk of long-term unemployment, ultimately creating a challenge for the disability benefit system to which people will often turn to at a later stage. This means that policies focusing on sickness and disability systems alone will not deliver.

## Tackling labour market exclusion via sickness and disability benefits

Mental health problems considerably increase the risk of leaving employment. At the same time, evidence suggests that the probability of moving on to disability benefit is strikingly higher for those with sick leave for mental disorders compared with sick leave for other reasons.[1] Previous work of the OECD shows that sickness absence for mental health reasons is a main precursor to a later benefit claim in Sweden (OECD, 2012). Early intervention and support for those on sickness benefit due to mental disorders is therefore crucial to prevent early labour market exit.

In Sweden, the extensive structural reforms to the sickness and disability system carried out over the past few years have been enormously successful in tackling the very large numbers of sickness and disability recipients. The paradigm shift in sickness and disability policy in this period is exemplary to other OECD countries (see Box 4.1 for more details). However, whether reforms have been equally effective for those suffering from mental disorders merits particular attention.

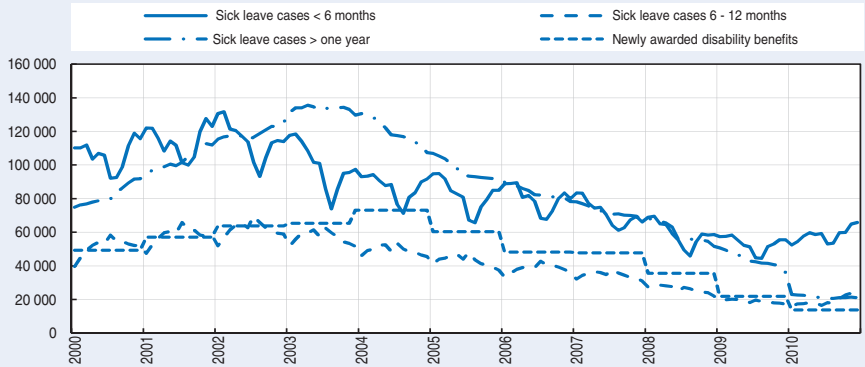
Box 4.1. **Key policy factors explaining the recent remarkable fall in sickness and disability beneficiary rates in Sweden**

During the last three decades, sickness absence volumes in Sweden have been among the highest in OECD countries. Sweden represented a classical example of a country where the sickness and disability benefit systems for a long time were used as a way to hide unemployment problems (OECD, 2010a). The trend increase in the number of people exiting the labour market prematurely has been broken only in recent years. Long-term sick leave of more than one year has fallen by 84% since its peak in 2003. Similarly, inflows into disability benefits have fallen by 80% during the same period.

Box 4.1. **Key policy factors explaining the recent remarkable fall in sickness and disability beneficiary rates in Sweden** *(cont.)*

**The four waves of incapacity benefit growth until 2010**

Cases of sick-leave and people awarded a disability benefit (monthly numbers)[a]




a. Sickness absence data are on a monthly basis, while the annual number of inflows into disability benefit is divided by 12 to derive a monthly estimate.

*Source*: Swedish Social Insurance Agency (SIA).

Since 2003, Sweden undertook a series of reforms to address the long-term structural problems with its sickness and disability policies. These included:

### Emphasis on early intervention: the new sick-leave process

The purpose of the new sick leave process is to provide incentives for a more active procedure and to prevent the risks of long periods of sick leave and ensuing permanent exclusion. The main feature is a much stricter timeline for work-capacity assessment at different stages: The work capacity of the person on sick leave is first assessed in relation to his or her own job, then after a maximum of three months in relation to other work with the same employer and lastly, after six months, in relation to the regular labour market as a whole to facilitate early return to work.

### Time limit on sickness benefit

The extreme sick leave periods in Sweden were unique, as there was no upper limit on the number of days for which sickness benefit can be received. As of 1 July 2008, sickness benefit can be paid for a maximum period of 364 days within a time frame of 450 days. Payment duration can be extended to 914 days maximum under certain conditions.

### Earned income Tax Credit

The introduction of an earned income tax credit (EITC) which created stronger incentives to stay in work. It is argued that the EITC may have had a substantial impact on time spent on sick leave. As those on sick leave are not entitled to the credit, it entailed an increase in the income from working relative to compensation for sick leave (absences of more than 14 days). It is estimated that the EITC may have shortened sick leave by around three days, or 7% (Hartman, 2011).

Box 4.1. **Key policy factors explaining the recent remarkable fall in sickness and disability beneficiary rates in Sweden** *(cont.)*

**Disability benefit is granted only in case of permanently reduced work ability**

Prior to the 2006 reforms, "lasting" impairment of work capacity was required which opened up the possibility of getting a either temporary or permanent disability benefit. The possibility of getting temporary disability benefits has been eliminated for those above 29 years of age. For the insured to be entitled to disability benefits, his or her work capacity is to be "permanently" impaired.

**Measure to stimulate labour demand of those with previous sickness benefit**

To encourage employers to hire people with a reduced work capacity, employers have the possibility to deduct an amount equal to twice the employer's social security contribution when hiring someone who has been on long-term sick leave or on disability benefits. Moreover, for people on disability benefits, the employer's contribution for sickness benefits has been abolished. Finally, employers do not have to pay sickness benefits for individuals who work and retain their disability benefits.

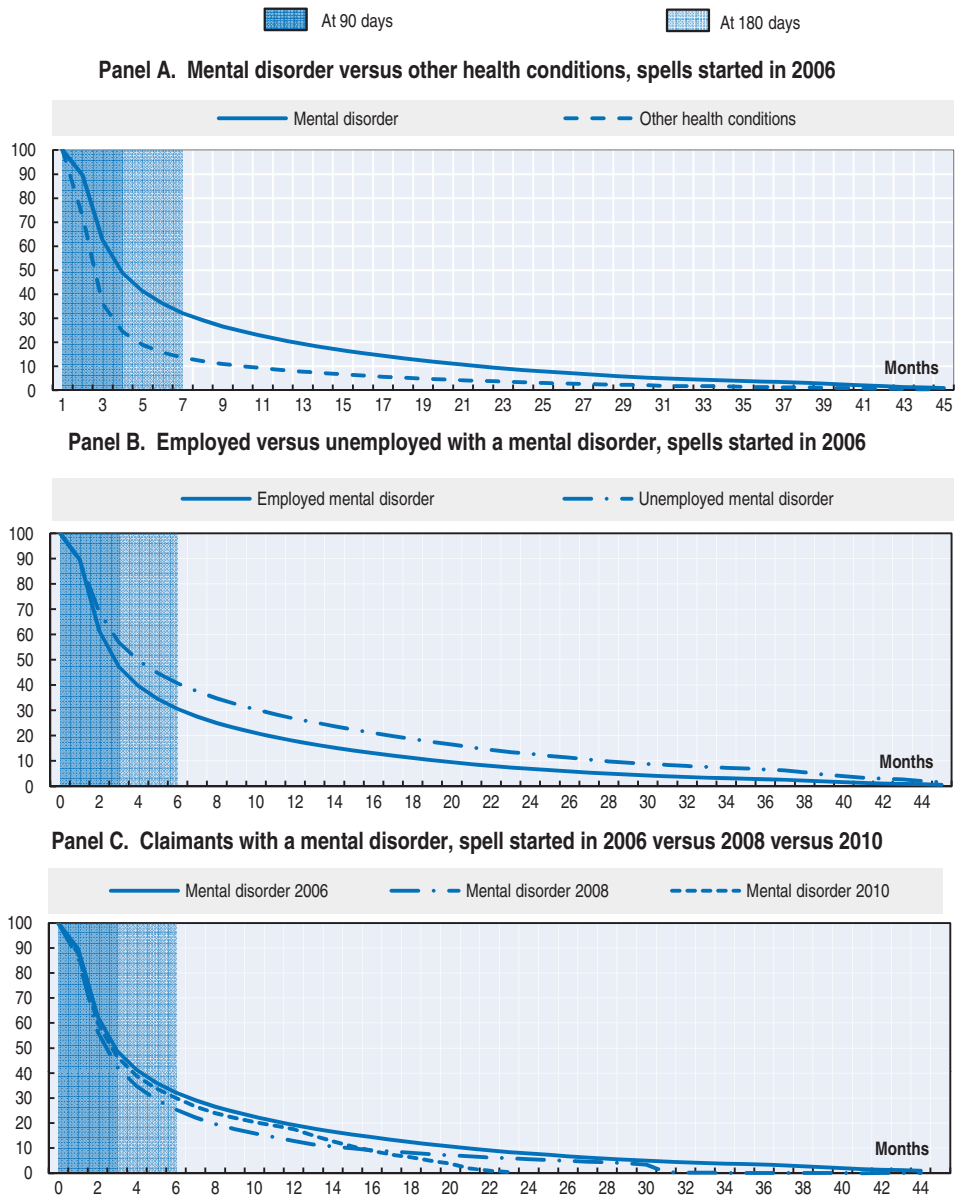
### *Sickness recipients with mental ill-health need to be a target group*

Figure 4.1 figure plots the monthly survival rates on sickness benefit for different beneficiary groups. A number of important findings emerge from these data:

- *Sick leave recipients with a mental disorder stay much longer on sickness benefit.* Panel A shows that over 75% of beneficiaries with no mental disorders have left sickness benefit within three months. The corresponding figure for those with a mental disorder is only 50%.
- *Unemployed with a mental disorder are at a much greater risk of being trapped in long-term sickness benefit dependency.* Absence duration is higher for recipients with a mental disorder in general, but unemployed are at a greater disadvantage. Around one-third of the unemployed with a mental disorder are still on sickness benefit after six months (Panel B).

Figure 4.1. **Mental disorders increase sickness benefit duration considerably**

Monthly attrition from sickness benefit for different groups of beneficiaries and different years of starting a sickness spell




*Source*: OECD calculations based on data provided by the Swedish Social Insurance Agency.

- *There is some evidence that the reforms have shortened durations of new sickness benefit claims, but that long-term benefit dependence remains a problem for the more "difficult" cases.* Panel C demonstrates that the overall impact of the reform has been mixed. Comparing sickness benefit spells starting in 2006 and 2008, the reforms seem to have shortened sick leave times for those with a mental disorder. The improvement is particularly apparent after the first three months – the first critical period in the Rehabilitation Chain. However, in 2010; initial survival rates are almost back to their pre-reform levels. One likely reason is that those exhausting their 2.5 year maximum benefit duration in 2010 can re-qualify following participation in a 3-month activation program; these "repeat" cases are then unlikely to exit the benefit rolls quickly, which pushes up measured benefit durations.

Overall, the results give a strong message that the longer a person is off sick, the more difficult it becomes for them to return to work and the less likely it is that they will return to work at all. This is particularly true for people with mental health conditions.

### *Previously unemployed with a mental disorder are a particular risk group*

Detailed SSIA data on destinations three months after ending a sickness spell in 2011 show much poorer outcomes in Sweden for those claiming sickness benefit out of unemployment *i.e.* those without a job to return to. For instance, almost 5% of those unemployed with a mental disorder move onto disability benefit, compared with 2.3% if unemployed with another illness and only around 1% for those claiming sickness benefit as an employee (Table 4.1). Those claiming sickness benefit via unemployment are also generally more likely to start a new sickness spell within three months or to register again with the PES; the latter is also more likely for those with a mental disorder who still held a job when first claiming sickness benefit.

The Dutch reforms show a similarity with the situation in Sweden today. In the Netherlands, where the sickness benefit scheme was reformed radically and sickness incidence fell accordingly, shows that unemployed persons on sickness benefits face major disadvantage. According to Everhardt *et al*. (2011), the Dutch sickness reforms were strongly beneficial for the employed group *i.e.* those who had an employer to return to, but not for the unemployed, thereby creating a new and growing insider versus outsider problem.

Table 4.1. **Unemployed sick persons are more likely to remain in the social system, especially if suffering from a mental disorder**

Share of individuals ending a sickness spell during 2011, by destination

| | Starting new sickness spell | | Registered with employment service | | Into disability | | Other (mostly into employment) | |
|---|---|---|---|---|---|---|---|---|
| | Mental disorder | Other illness | Mental disorder | Other illness | Mental disorder | Other illness | Mental disorder | Other illness |
| Women | 18.2 | 19.1 | 3.3 | 1.6 | 1.6 | 0.8 | 76.9 | 78.4 |
| Men | 17.8 | 14.3 | 4.6 | 2.4 | 2.3 | 1.1 | 75.3 | 82.2 |
| Employed | 17.8 | 16.9 | 3.5 | 1.8 | 1.1 | 0.7 | 77.6 | 80.6 |
| Unemployed | 19.4 | 19.9 | 4.4 | 2.8 | 4.8 | 2.3 | 71.5 | 75.0 |
| Total | 18.1 | 17.3 | 3.6 | 1.9 | 1.8 | 0.9 | 76.5 | 79.9 |

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

### *Early intervention in the rehabilitation chain needs to be strengthened*

The biggest change in the sickness insurance rules is the introduction of a *rehabilitation chain* with fixed time limits specifying when work capacity is to be assessed in accordance with various criteria (Box 4.1). Under the new process, the SSIA and the PES co-operates in regards to vocational rehabilitation of the individuals who have not returned to their original jobs or found new jobs.[2] This regular collaboration includes a contact meeting after between 91 and 180 days for those deemed unable to return to their employer before six months. The next point of contact is after six months (at the "handover" meeting) if a client is found to have remaining work capacity and, accordingly, comes under the responsibility of the PES.

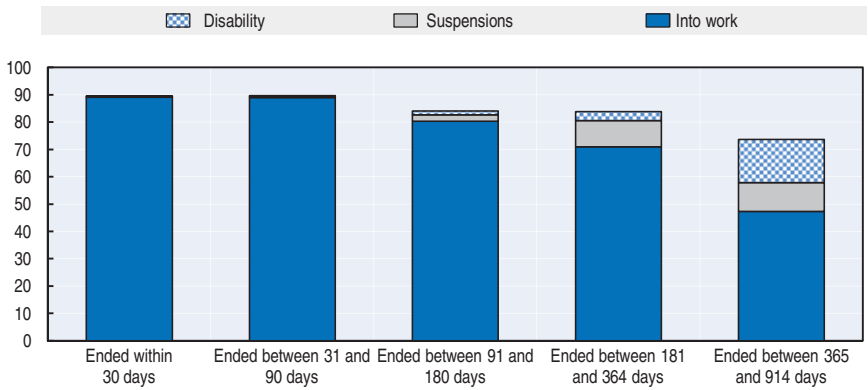
These meetings form an important part of the sick-leave process as the objective is to keep persons on sick leave attached to the labour market by assessing the need for continued support from the PES. For example, after the initial assessment, the PES can offer various services including guidance on the labour market, job-matching services and advice on working conditions in different jobs. The meetings also offer the opportunity to decide upon appropriate vocational rehabilitation measures.

Despite the improved co-operation between SSIA and the PES under the new rehabilitation chain, there remain deficiencies in the early intervention process. Administrative process data show that only 4% of cases that lasted between 91 and 181 days during the period January 2010 to June 2011 were offered a contact meeting (SIA, 2012). Men are offered contact meetings to a greater extent than women, and people with musculoskeletal diseases more often than other diagnostic groups. Moreover, results showed that purpose and content of the contact session is often unclear to the client. Follow-up contact sessions were also absent in a majority of the cases.

Labour market attachment through contact meetings with the PES and the SSIA are particularly important in the early phase of a sickness spell for persons who have a mental disorder: they are more likely to get their sickness benefit entitlement extended beyond 180 days because they are more often – rightly or wrongly – considered to be unable to perform *any* job in the labour market (the criterion applied after 180 days). Initially, around 19% of all new sickness cases concern people with a mental or behavioural disorder. This share increases over time and reaches 37% of all cases fully exhausting their entitlement. This is problematic because the chances to return to employment are falling sharply over time. To begin with, some 90% of all sick leaves end in employment, but this proportion falls to 80% after 90 days, two-thirds after 180 days and 50% after one year (Figure 4.2).

Figure 4.2. **The chances to return to employment fall sharply with the duration of sick leave**

Destinations upon ending a sickness benefit, by duration of sick leave




*Source*: OECD calculations based on administrative data provided by the Social Insurance Agency.

At the same time, the very low number of contact meetings can partly be explained by the fact that sickness beneficiaries are not obliged to attend the meeting with the employment service. Mandatory attendance in early phase of sickness spell should be considered for certain groups who may profit from early guidance on labour market services and rehabilitation opportunities to prepare them for the future.

### *Improved co-operation but incentives for the PES remain weak*

Since February 2012, the SSIA and the PES launched a new co-operation model with the aim to use the competences of both authorities whenever it seems useful in the process depending on individual's circumstances (instead of at the three-month stages). This revised process with greater flexibility is reflective of a change in the right direction and may optimise the chances of a quicker recovery and return to the labour market. However, there are concerns whether the new rules under the revised process will be enforced properly or the desired level of co-operation between the SSIA and PES is reached in the absence of hard financial incentives. The fact that employment services are under the responsibility of the PES and payment of sickness benefit remains under the SSIA is likely to give rise to perverse incentives to the PES, undermining the desired effects of the rehabilitation chain. In other words, the PES has little incentive to intervene early in the sickness spell as the cost of prolonged sickness absence is borne by the SIA.

It is important to bear in mind that if the revised model fails to produce better outcomes, other ways (*e.g*. monetary incentives) should be considered to entice co-operation and ensure adequate employment support for those on sickness benefits. This would make sense because the lack of action in the earlier phase of sickness absence generates costs for the unemployment system in the long run *i.e.* after persons have been found to be able to work at the six-month period. This is particularly the case for the unemployed with mental health problems as they do not have a job to return to and may eventually end up in the unemployment system at a later stage.

### *Work introduction programme could help more of the long-term sick in their return to work*

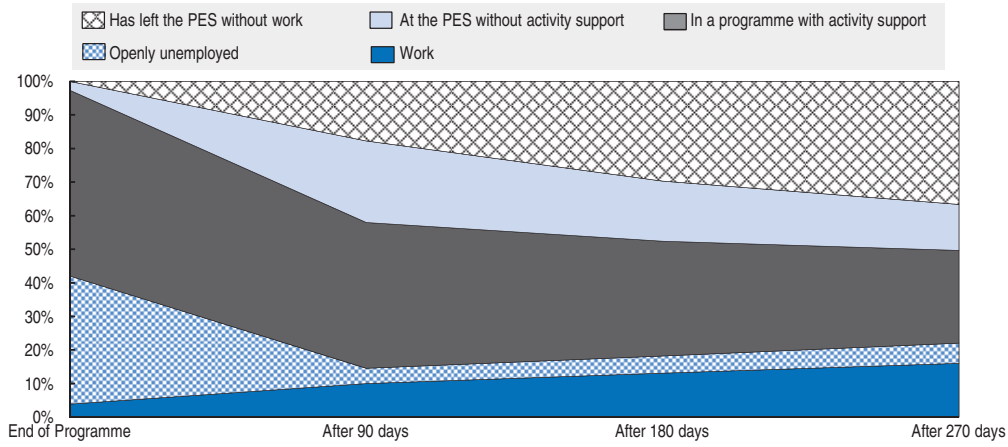
A particular issue is the question of how the public system is coping with those who reach the very end of a sickness spell of 914 days; with almost four in ten of those people having a mental and/or behavioural disorder. SSIA data suggest that about one in six of those people will receive sickness benefit again only three months later, while some 5% move onto disability benefit.[3] The large majority of all those exhausting the extended sickness benefit entitlement, however, move onto the Work Introduction Programme (WIP). This is a three-month programme offered by the PES to this particular group, using special earmarked resources to help these clients to return to work. After the three months, clients can either return back to the SSIA or stay with the PES and participate in other labour market programmes.

The aim of the WIP is to enable and prepare persons who have been out of the labour market for a long time for participation in the different programmes at the PES depending on their needs to get back to work, including *e.g.* help to develop motivation, counselling, work experience or meeting specialists such as psychologists, job coaches etc.

Figure 4.3 shows the transitions of all individuals who reached the end of their work introduction programme. Around 50 000 persons participated in this programme in 2011, of which some 38 600 were followed up after completion. Immediately after the end of the programme, some 40% moved into open unemployment while almost 60% stayed in an employment programme with activity support (equivalent to unemployment insurance). Less than 5% moved into work directly. Open unemployment declines quickly to less than 5% ninety days later. However, few people who have ended the three-month programme find a job: 270 days later, still less than 15% are in work. The group leaving the PES without work (mostly discouraged workers) reaches over 30% after 270 days. This leaves about half of the group with the PES nine months later, either with or without activity support.

Figure 4.3. **Very few people move into employment after completion of the Work Introduction Programme**

Transition rates over 270 days of PES clients who completed the three-month Work Introduction Programme in 2011




*Source*: Administrative data supplied by the public employment service (PES).

All in all, it is plausible to say that though participation in the work introduction programme facilitates further engagement with the employment services, it is not very effective in promoting a return to employment among participants. It is not surprising that after 914 days on sickness benefit and

another three months in the WIP, participants are not able to regain employment quickly. In view of this, interventions should come much earlier *and* for longer. This could mean that either the sickness benefit duration is being cut accordingly or that the PES has to cover the allowance earlier in the sickness spell – de facto – maintaining the key elements of the WIP programme, including the participation requirement. In addition, the revised co-operation model described above offering employment support earlier in the sickness spell may have positive knock-on effects on WIP as clients receive on-going employment support during their sickness period.

Overall, one important conclusion that can be drawn from the above evidence is that the sickness benefits reforms in Sweden have been enormously successful due to its threat effect on individuals rather than by giving people the right support. That is, an increased hazard from sickness absence when individuals are monitored and before entering rehabilitation schemes.[4] However, the threat effect has been less effective for claimants with mental ill-health, but also unemployed sickness benefit claimants more generally and especially unemployed claimants with mental ill-health. More could and needs to be done to ensure that policies target these major risk groups.

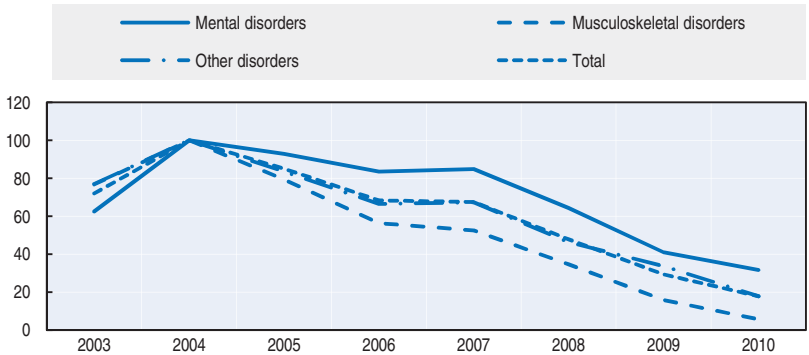
### *The number of new disability claims has dropped drastically*

Sickness absence is the main pathway into disability benefits in Sweden, as in most OECD countries. As such, the decreasing levels of long-term sickness absence are also reflected in decreasing levels of disability claims. Similar to the sickness benefit scheme, the rate of disability inflow dropped very fast since 2004 (Figure 4.4, Panel A). By 2010, it had dropped to around 20% of the 2004 peak level. The disability inflow for musculoskeletal disorders dropped even further and reached less than 5% in 2010. As a consequence, the percentage of the inflow due to psychological disorders continued to rise: in 2011, more than 60% of all new claims were diagnosed with a mental disorder – by far the highest share across the OECD.

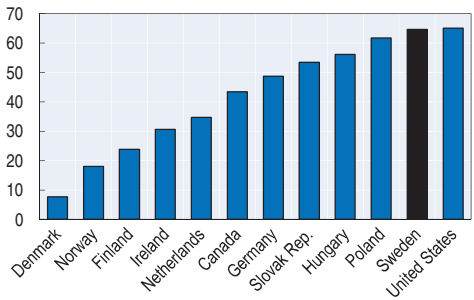
Although the significant drop in inflows to disability benefit is a big achievement, there are some concerns that the disability system may have become too strict and harsh providing inadequate income security for those who need it the most. Some spectators argue that the criteria for being eligible for disability benefits *e.g. permanent impaired work capacity* are too stringent (Hartman, 2011). The strictness of the benefit system is reflected in the very high rejection rates in Sweden which are now one of the highest in OECD together with the United States (Panel B). Currently, almost two-thirds of all benefit applications are declined.

Figure 4.4. **New disability benefit claims are decreasing for all disorders and claims are very often rejected**

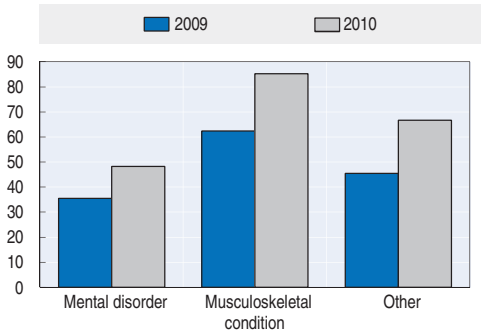
**Panel A. New disability benefit claims by main category of disorder (persons index) 2004 = 100**




**Panel B. Benefits rejected as a share of all benefit applications, 2008[a,b]**




**Panel C. Rejections by condition[c], 2009-10**




a. Data for Poland refer to 2003; 2004 for Canada, Ireland and the Slovak Republic; 2009 for Denmark and 2010 for Sweden.

b. Data for Ireland refer to persons applying for the Illness benefit after two years; for Canada and Germany, the contributory pension only and for Poland to the KRUS pension scheme only.

c. Mental disorders include mental retardation, organic and other mental disorders which we do not consider as mental health conditions elsewhere in the report.

*Source*: OECD questionnaire on mental health.

Tighter access to the disability benefit is beneficial for many persons as they move to other working-age benefits which offer better activation and increase their chance of returning to work. However, the system will need to carefully monitor and follow-up those who are rejected for two key reasons. First, many rejected claimants (who have worked before) are likely to qualify

for sickness benefit instead and are more likely to reapply at a later stage and often end up on disability rolls eventually. Second, other claimants may fall out of the benefit system completely (particularly those who do not qualify for sickness benefit), leaving them to an increased risk of poverty. Such applicants are an at-risk group and require special support to get back into the labour force (OECD, 2010b).

More detailed data show a very fast increase in rejection rates in Sweden (Panel C). Interestingly, both the rejection rates themselves and the increase in these rates from 2009 to 2010 were lowest among persons with a mental disorder. The rejection rate for this group is "only" 50% compared with 80% for claims with a musculoskeletal condition. The differences in the rejection rates could be explained by the nature of mental disorders which complicates assessments and subsequent eligibility determination. Assessments of work capacity of claimants are a fundamental part of the process to moving on disability benefits. Understanding how claimants with a mental disorder are assessed is therefore critical. This issue is discussed in the following section.

### *Assessment of mental health problems is problematic for social insurance doctors and general practitioners*

Currently, there is no explicit mental health component in the assessment tool determining eligibility for disability benefit. Adapting work capacity assessment tools remain a difficult challenge for the disability benefit authorities across all OECD countries. One major difficulty with determining impairment for those with mental disorders is the heterogeneity of this group. Some individuals may meet diagnostic criteria for a severe disorder without having significant impairments in functioning and other individuals with "mild" diagnoses suffer functional limitations that impede their ability to work. Impairments can be temporary or persistent and can improve and recur. Despite these difficulties, other OECD countries such as Australia, the Netherlands and the United States have made attempts to directly address mental health problems in their assessment tools.

In addition, the lack of training and awareness of mental health problems among those assessing the claimants' work capacity is a major obstacle. Anecdotal evidence suggests that SSIA caseworkers often struggle assessing persons diagnosed with a mental disorder. Instead, they rely extensively on assessments carried out by general practitioners (GPs) and, possibly, psychiatrists which tend to focus on incapacity rather than workability. Social insurance doctors at the SSIA have an important role in granting disability benefits and are increasingly involved in advising SSIA caseworkers to assess benefit claims accurately as well as educating GPs to focus on workability. However, social insurance doctors are too few in

numbers and are unable to intervene in all disability claims. Only some 8% of all sickness benefit cases and around one-third of all disability benefit eligibility assessments involve medical advisors of the SIA.

### *Sickness absence guidelines on psychological disorders are an encouraging step to shift GP attitudes*

GPs continue to have a strong overarching role to play as gatekeepers to the social insurance system and thus are in a key position to determine the take-up of sickness and disability benefits. The newly developed diagnosis-specific medical guidelines for GPs, to limit the amount of time off work to the minimum appropriate have had a significant impact on GPs attitudes towards prescribing sick leave.[5] The broad rationale behind this innovation is that excessively long sick leave can be medically detrimental for some conditions. In this respect, the inclusion of guidelines recommending "appropriate periods of sickness absence" for psychiatric disorders, namely anxiety, depression and schizophrenic conditions added in 2008, are highly welcome since evidence shows that with the appropriate treatment most persons with moderate disorders can quickly return to work. By way of example, the guidelines for depression recommend that persons with uncomplicated first-time depression can reach improved functionality within three months of adequate treatment (see Box 4.2 for more details). This initiative represents an important example for other OECD countries struggling with shifting GP attitudes as well as a tool to empower GPs to prescribe more adequate (*i.e.* shorter) sick leave for patients with psychological disorders.

That said, guidelines for sickness certification may not be sufficient for specialists dealing with mental disorders. Previous evidence in Sweden has shown that physicians working in psychiatry expressed more need of knowledge and skills in relation to the process of certifying sick leave even after controlling for demographic and work-related factors compared to other categories of health professionals (Lofgren *et al*., 2010).

Moreover, there is still room for improving co-operation between GPs and SSIA caseworkers. On the one hand, GPs continue reporting major difficulties when involved in the assessment of work incapacity per se and the duration of such incapacity (Engblom *et al.*, 2011). On the other hand, most caseworkers report the lack of vital information such as proper medical diagnoses and assessments of the patients work capacity on sickness certificates (Thorstensson *et al.,* 2008). Poor quality of certificates and their re-remitting have shown to prolong sickness spells by 30% in Sweden (Johansson and Nilsson, 2012).

### Box 4.2. **National Guidelines on sickness absence for persons with depression**

Physicians play an important role in the sickness insurance system by acting as gate-keepers. In 2005 the National Board of Health and Welfare developed new ways to improve quality in the sickness certification process in an effort to reduce the high sickness absence levels. The National Board of Health and Welfare has to date published 120 recommendations covering approximately 80% of all sickness certification. The recommendations cover different aspects of relevance for judging the individual case *e.g.* expected prognosis, effective treatment and the length of sickness absence. The recommendations in the guidelines are based on a combination of available scientific evidence and consensus among different specialists.

The following example shows parts of the recommendations on depression.

**Sickness absence guidelines for depression**

| | |
|---|---|
| Symptoms, prognosis and treatment | Depressive episode is a first time occasion. The diagnosis could cover a range of different conditions with partly different symptoms, prognosis and treatability. The condition includes both psychological and somatic symptoms. Cognitive function is often affected.<br><br>The goal for the treatment is full recovery. The severity of the depression should be monitored continuously and the treatment strategy evaluated. |
| Function | Fatigue, lack of energy, indecisiveness, loss of memory, lack of initiative, lack of motivation, loss of stamina often affects function negatively. Social avoidance is common. Severe depression can lead to problems dealing with everyday tasks and incapacity to take basic care. |
| Estimated time for healing and normalisation of function | Uncomplicated first time depression reaches improved functionality within three months with adequate treatment. |
| Recommendations concerning work capacity | - Mild first-time depression seldom gives cause for sickness absence. Work capacity can be reduced one to three months from treatment. Part-time sickness certification should be considered.<br><br>- Severe first-time depression may cause reduced work capacity for up to six months from start of treatment. Symptoms can stay longer. There are big individual differences. |

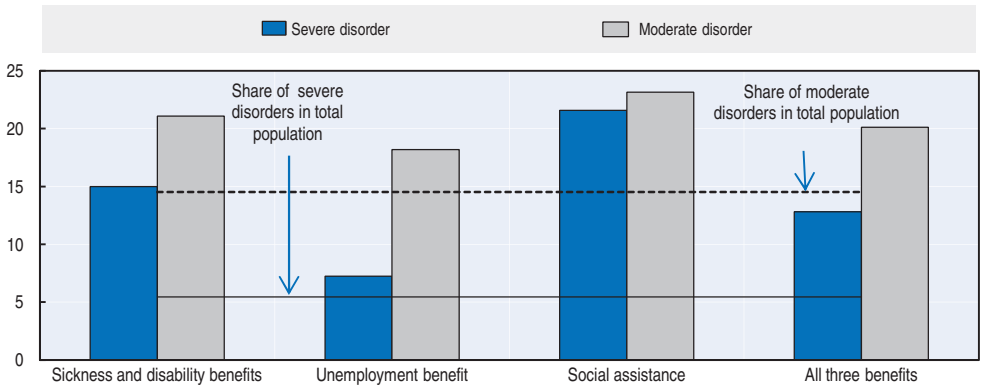
*Source*: National Board of Health and Welfare.

## Addressing mental ill-health in other working-age benefits

Mental ill-health is a big challenge facing the entire welfare system as persons with mental health are highly over-represented across the different welfare schemes. On average, across all major working-age benefit schemes, the incidence of moderate mental disorders is as high as 25% and almost 15% for severe mental disorders – taken together this accounts for 40% compared to 20% in the general working-age population (Figure 4.5). One in five unemployment beneficiaries and almost one out of four recipients of social assistance suffer from a mental disorder. Furthermore, according to the Swedish Health Interview Survey, up to 50% of long-term unemployed suffer from a mental disorder. Undiagnosed and unidentified mental health problems among the unemployed are often a major barrier for a successful return to the labour market and may also increase the risk of resorting to lifelong disability benefits (OECD, 2012). Early intervention and support for the unemployed and those on social assistance is therefore critical.

Figure 4.5. **Mental disorders are frequent in recipients of unemployment and social assistance benefits**

Prevalence of severe and moderate mental disorders across different benefit schemes, 2009/10




*Source*: Living Conditions Survey, 2009/10.

### *Identification of unemployed persons with mental disorders is largely missing*

Jobseekers go through an initial basic assessment based on previous job experience, education level etc. to determine the level of support needed, but there is no systematic procedure of identifying mental disorders and the resulting support needs. There is an enormous reliance on caseworkers to profile jobseekers; decisions on further referrals and the type of measures

offered to the jobseeker are taken by the caseworker, sometimes involving psychological testing (which is available internally at the PES). The employment service, however, has started to make efforts to focus more on cognitive functions across the board especially for jobseekers with previous long-term sickness history who may need specialist support. But assessment for identifying psychological disorders and appropriate support for the unemployed remains patchy.

The lack of both awareness of this issue and the tools available for identifying mental ill-health at a relatively early stage of an unemployment spell is particularly worrisome in view of scientific evidence showing that mental health deteriorates with length of unemployment.

The extent to which mental health problems are identified among jobseekers depends on both the resources of the PES and the ability of caseworkers. The PES in Sweden has specialised resources to deal with those with mental disorders but the high caseload is a big restraint to give dedicated time to understand client needs. About 330 persons in the PES work as psychologists, 200 as occupational therapists and 30 as psychotherapists: this compares with a number of 169 500 jobseekers with a mental health disorder registered at the PES in 2010.[6] This suggests that the average caseload among specialist staff often exceeds 308. Such high caseload figures are bound to hamper the effectiveness of specialist interventions and identification of persons with mental health problems. By comparison, evidence from countries like Denmark and the United Kingdom reveal that low caseload levels among specialist staff are critical in giving the right support and a key factor to success to return to work.[7]

### *The high prevalence of mental disorders in social assistance clients needs to be tackled*

Given the strong positive correlation between unemployment duration and mental ill-health, it is not surprising that the prevalence of mental disorders is the highest among social assistance recipients as they are often furthest away from the labour market. Moreover, with the tightening of unemployment benefits, sickness insurance and disability benefit in Sweden, social assistance is becoming the ultimate option for maintaining some income security. In this context, identifying mental disorders of recipients of social assistance and offering them comprehensive support is even more critical to minimise the risk of these persons reverting back to sickness and disability benefits.

Little is known on how municipalities identify mental health problems, if at all, and the kind of support they provide to these clients. According to a qualitative study examining the conditions of social assistance recipients

with chronic illnesses in Sweden, lack of diagnosis were hindering clients' recovery process (Marttila *et al.,* 2010). The study also argues that social assistance recipients with ill-health, have limited access to rehabilitation measures and had no access to rehabilitation programmes offered by the social insurance even though chronically-ill persons on social assistance have the same kinds of needs for rehabilitation as those who qualify for sickness benefit. Municipalities have no set procedures to intervene in a systematic way. Intervention and support is largely dependent on a range of factors, including the kind of health problem clients are suffering from, in which municipality they live and which professional they meet.

Accessing labour market programmes is another challenge facing recipients of social assistance as they are required to register both at the PES and with the municipal services. To activate persons on social assistance, municipalities offer active labour market programmes, however, the effectiveness of these programmes differs between municipalities and is perceived to be lower than those provided by the PES. Accordingly, those who are further away from the labour market tend to get less efficient support.

In sum, policy makers should pay particular attention on identifying mental health problems of persons relying on social assistance in a systematic way as many of them have been away from the labour market for a considerable period while others have previously been rejected by the sickness and disability system. Importantly, co-ordination between local health and social services is critical for this group as they are particularly vulnerable to a further decline in their health status and are at a high risk of full social exclusion. There is also a need to further develop ways of entering the labour market.

### *Participation of persons with a mental disorder in active labour market programmes is low*

The PES offers a number of services specific to disabled people but none exclusive to people with mental health problems. In principle, persons with mental health problems can participate in all PES programmes but there also special programmes such as Development Employment, Security Employment, Public Sheltered employment and Samhall directly targeted at persons with reduced capacity to work.[8] The majority of these programmes are offered to people with severe disabilities, and therefore likely to include persons with severe mental disorders, but rarely with a mild or moderate mental disorder.

Administrative data show that, overall, very few persons with mental health problems participate in labour market programmes. Barely 8% of

persons in programmes at the employment service are registered as having a mental disorder (Table 4.2). The true extent of those with mental disorders participating in active labour market policies, however, is likely to be much higher in reality given the level of "hidden" mental health problems among beneficiaries of unemployment benefits. Not surprisingly, a significant proportion of persons with mental health problems participate in programmes directly linked with reduced functional capacity. They are also more likely to be found in programmes such as vocational rehabilitation and Special New Start. This is probably attributed in part to the increased vocational rehabilitation efforts offered to those with long-term sickness benefits.

Another question is how effective PES programmes are for jobseekers with a mental disorder.[9] This information is also shown in Table 4.2. Generally, all programmes taken together three in ten participants with a mental disorder end up in employment – compared with four in ten of all other participants. Importantly, those with a mental disorder are far more likely to end up in subsidised employment rather than employment in the open labour market: three in four of those with a mental disorder finding employment, compared to one in three otherwise. By and large, this finding is also true across different employment programmes *i.e.* they are less effective placing persons with a mental disorder into the open labour market with the exception of New Start Jobs (aimed at lowering payroll taxes).

While subsidised employment can provide an initial foothold in the labour market, there is a growing concern that targeting of wage subsidies in general is getting weaker and becoming an expensive reintegration measure as they are not adjusted over time according to clients work capacity or productivity. This argument is particularly relevant for jobseekers with mental disorders of a fluctuating nature which can get better over time with appropriate treatment. The targeting of active labour market programmes could be improved by further developing the use of profiling to identify individuals at risk of becoming long-term unemployed. In this context, systematic identification of persons with mental disorders would also be critical since many of them could then be offered further support early on and in turn allow better targeting of employment programmes.

Conventional labour market programmes alone, however, may not succeed in helping the unemployed who already suffer from a mental disorder or those who are at a high risk of developing more serious disorders *i.e.* the long-term unemployed. Evidence suggests that ALMPs that include resilience-building mental health promotion programmes for unemployed people such as group psychological support for unemployed people can mitigate symptoms of depression and increase self-esteem and thereby increase re-employment rates (Vuori and Silvonen, 2005). A more recent

study argues that combining vocationally-orientated cognitive behavioural therapy with broader labour market programmes can be effective in promoting work among the long-term unemployed (Rose *et al.,* 2012).

Table 4.2. **PES clients with a mental disorder tend to be placed into subsidised work**

Persons who left PES programmes in December 2010-November 2011, persons employed three months after the programme ended

| | Total participants | | Subsidised employment | | Persons in open labor market | | All | |
|---|---|---|---|---|---|---|---|---|
| | Total participants | Share of those with a mental disorder | Share of those with a mental disorder | Share of those without a mental disorder | Share of those with a mental disorder | Share of those without a mental disorder | Share of those with a mental disorder | Share of those without a mental disorder |
| New start jobs | 37 508 | 2.3 | 8.4 | 1.2 | 25.1 | 42.0 | 33.5 | 43.2 |
| Special New start jobs | 634 | 29.3 | 38.7 | 36.8 | 28.0 | 30.4 | 66.7 | 67.2 |
| Development employment | 3 395 | 28.2 | 56.3 | 56.3 | 4.5 | 3.7 | 60.8 | 60.1 |
| Security employment | 2 152 | 20.7 | 9.4 | 12.8 | 10.1 | 7.9 | 19.6 | 20.7 |
| Wage subsidy | 15 582 | 16.2 | 21.2 | 26.1 | 15.2 | 11.9 | 36.4 | 38.0 |
| Sheltered public employment | 1 779 | 17.5 | 36.0 | 26.8 | 4.5 | 3.3 | 40.5 | 30.1 |
| Start your own business programme | 7 521 | 2.7 | 0.0 | 1.1 | 73.8 | 85.3 | 73.8 | 86.4 |
| Special recruitment incentive within the Job and Development programme | 4 314 | 2.5 | 33.6 | 39.0 | 0.9 | 7.2 | 34.5 | 46.2 |
| Work experience placement | 30 307 | 4.5 | 35.4 | 22.2 | 7.8 | 19.1 | 43.2 | 41.3 |
| Trial opportunity | 2 951 | 5.5 | 35.0 | 23.1 | 8.6 | 12.2 | 43.6 | 35.2 |
| Youth Job Programme | 73 055 | 1.0 | 23.1 | 7.3 | 10.5 | 42.9 | 33.6 | 50.2 |
| Job and Development programme | 70 319 | 3.8 | 36.6 | 27.6 | 11.0 | 27.0 | 47.6 | 54.6 |
| Vocational Rehabilitation Programme | 33 987 | 26.7 | 28.1 | 24.7 | 5.4 | 6.1 | 33.5 | 30.8 |
| Activities within vocational guidance and placement | 7 691 | 23.6 | 9.2 | 7.0 | 4.5 | 5.3 | 13.7 | 12.3 |
| In-depth assessment and vocational guidance | 12 147 | 21.7 | 7.0 | 2.7 | 2.8 | 3.8 | 9.8 | 6.5 |
| Job and Development programme – Phase 3 - Work experience placement | 10 658 | 5.1 | 44.2 | 37.0 | 10.4 | 16.6 | 54.6 | 53.7 |
| Employment training programme | 13 883 | 4.5 | 11.3 | 10.5 | 14.6 | 24.2 | 26.0 | 34.7 |
| Preparatory training course | 25 726 | 9.9 | 5.2 | 4.7 | 2.5 | 6.8 | 7.7 | 11.5 |
| Total | 353 609 | 7.8 | 23.2 | 15.9 | 8.1 | 26.9 | 31.3 | 42.8 |

*Note*: Mental health problems are coded as those having "Psychiatric disability" in the PES administrative data.

*Source*: Administrative statistics from the public employment service (PES).

### *PES co-operation with employers to retain marginalised workers is promising*

The PES currently aims to work more closely with employers for their sickness benefit clients (the fastest growing clientele); such co-operation will be essential to ensure that the new sickness benefit rules – with its early referral to the entire labour market after a period of only six months – can be enforced. More recently, the PES (in 2012) initiated a pilot project with co-operation between the Swedish Work Environment Authority known as

the *Job Coach Programme* to increase co-operation with employers. The programme essentially involves job coaches with special competence in working conditions with the aim to *i)* offer support to employers to understand psychosocial environment issues at their workplace; *ii)* smooth out the transition to work for jobseekers who return to work after a considerable period; and *iii)* help employers retain those who return to work (Box 4.3).

Box 4.3. **Job Coach programme has potential to reintegrate long-term with mild disorders back into the labour market**

The main target groups of the Job Coach programme are long-term unemployed and those who have a disrupted record of employment and PES programme participation *i.e.* clients who move in and out of employment or PES programmes. Although, sickness beneficiaries and those with mental health disorders are not targeted explicitly, many of them will fall under this category.

The job coach can be a psychologist, a sociologist or a work environment specialist with a minimum experience of one year in the field of psychosocial work environment. The programme lasts for three months during which the employer, the jobseeker and the PES have a minimum of four meetings and unlimited support to employers through the telephone. In the first meeting, the job coach meets solely with the jobseeker to understand his or her needs and barriers to return to work. The second meeting will also include the employer and an "introduction plan" will be set up to secure a good entry into work. The last two meetings aim to evaluate the plan and action of employers and to develop recommendations for further improvement.

So far, there is no evidence available on the success of the programme but evidence from other labour market programmes such as supported employment targeted at hard to place client groups show that co-operation of this kind can facilitate job retention and early return to work.

## Conclusion and recommendations

By and large, reforms of sickness and disability benefits have been effective in tackling long-standing problems of labour market exclusion. Yet, an important challenge is to ensure that *i)* the impact of the recent measures are sustained; and *ii*) former recipients of sickness and disability benefit move into, and stay in, employment. A particular priority is to ensure that improved gate-keeping mechanisms co-exist with support measures that help those with mental health problems as they tend to stay on sickness benefit for longer compared with other groups. Similarly, efforts need to be boosted for the previously unemployed to avoid creating inequalities

between insiders and outsiders. All these challenges warrant systematic early intervention in the sickness process; better co-ordination between the SSIA and the PES as well as employers and strengthening reintegration measures for the long-term sick.

Another concern is whether access to disability benefit has in fact become too strict with the new rules of "permanent impairments" along with abolishment of the temporary disability benefit. For many individuals with work capacity, moving from disability benefit into work or other working-age benefits that offer better re-employment measures and services would be an improved outcome. However, there is a risk that some people might completely fall out of the welfare system leaving them exposed to an increased risk of poverty.

Policy makers in Sweden also need to shift their attention to tackling mental health problems among the unemployed, and in particular to those receiving social assistance benefit where persons with mental health problems are over-represented. To achieve these goals, the following actions could be envisaged.

### *Strengthen early intervention and reintegration measures in co-operation with the public employment services*

- *Provide adequate follow-up support to workers with mental health problems returning to their previous jobs upon exiting sickness benefit*. Persons with mental disorders often require extra support to return to their original jobs. This would require *i)* strengthening links with employers, and *ii)* building up capacity within SIA. Other options would include out-sourcing services such as fit-for-work in the United Kingdom whereby a team consisting of employment advisors and psychologists work with employers to support persons returning to their jobs and to prevent sickness absence.

- *Mandatory participation in interviews with the PES during the first six months of a sickness spell.* This would improve labour market attachment especially for those with mental health problems and the unemployed to facilitate early return to work.

- *Strengthen financial incentives for the PES to deliver services for the sick unemployed*. Currently there is a lack of commitment, and no consequences of non-commitment; this can be changed by putting the right incentives in place – *e.g.* in the form of co-payments for sickness benefit for the unemployed. Alternatively, consider setting up one stop-shop type services *i.e.* make the PES

fully responsible for dealing with, and offering programmes to, both the unemployed and the sick, similar to the job centres in Denmark.

- *Work Programme should be offered much earlier in the sickness spell.* The current arrangement of offering the Work Programme to the long-term sick comes far too late in the sickness process. Systematic support should be offered not only after exhaustion of the 2.5-year sickness benefit entitlement but through the entire sickness spell. Evidence suggests that re-employment probabilities fall rapidly with duration of sickness absence. At the same time, outcome-based research should be performed on the effectiveness of the programme.

### *Re-balance strict eligibility and adequate income security*

- *Address mental health functioning in the assessment tool to determine disability benefit eligibility.* Consider adopting a multidimensional assessment framework as used in other OECD countries (*e.g.* Australia, Denmark and the United States; OECD, 2012). To do this effectively would require mental health related training for caseworkers and better collaboration with doctors.

- *Follow-up of rejected claimants of disability benefit.* Intervention and support of rejected disability claimants should be considered in order to prevent future disability claims; as well as improving their chances to return to the labour market and to reduce poverty risk. A "redeployment procedure" as used in Luxembourg could be envisaged for those who are unable to return to their jobs (OECD, 2010b).

### *Prevent mental health problems among the unemployed*

- *Adopt a screening tool that can be used by caseworkers dealing with unemployed.* This would help identification of mental health problems and the resulting labour market barriers. This should be complemented by providing guidelines to caseworkers on when and who to screen and what to do next. Depending on the result of the screening; relevant experts such as psychologists should be involved if necessary. The same tool and approach can also be used by social workers dealing with social assistance clients.

### *Improve effectiveness of labour market programmes*

- *Combine job-search programmes for those at risk of long-term unemployment with psychological support programmes for mild to*

*moderate disorders.* This would support those who may already suffer from a mental disorder and help to break the vicious circle of unemployment and mental ill-health long-term unemployment. Providing mental health services at employment offices can be achieved through: *i)* purchasing external health services from the local counties and *ii)* integrating certain health services in the PES.

- *Target the Job Coach programme explicitly towards persons with mental health problems*. People with mental health problems need re-employment support which should include close mentoring and on-the-job coaching once they are back in the workplace. The current Job Coach programme is well placed to provide continuous support as well as address psychosocial risk factors at the workplace.

## *Notes*

1. Kivimaki *et al.* (2008) identified diagnosis-specific sick leave as a key risk marker for a subsequent disability benefit. Sick leave with a mental disorder predicted a 14-fold excess risk of a later disability benefit, relative to the total population, and sick leave with a musculoskeletal disease a 5.7-fold risk.

2. The SIA is responsible for the rehabilitation of individuals in the sickness and disability insurance programmes. Rehabilitation can be of medical, social or vocational character. The agency assesses the need for rehabilitation and co-ordinates the rehabilitation process, but does not provide rehabilitation services. The health care system provides medical rehabilitation, the social services provide the social rehabilitation and the employment service provides vocational rehabilitation for individuals who are unemployed or unable to return to their previous workplace because of health impairment.

3. Moves onto disability benefit are typically occurring after one year on sickness benefit, not after 914 days; see Figure 4.2.

4. Engström *et al.* (2012) who studied the effects of two types of early interventions taken by the Swedish Social Insurance Agency in 2007 on individuals with sickness benefits found no evidence of positive effects from vocational rehabilitation but, instead, a strong *threat effect* through early screening and monitoring of eligibility for sickness and disability benefits.

5. Evidence suggests that sickness absence guidelines for the most frequent illnesses have contributed to much reduced incidence and shorter spells of sickness absence and a much narrower distribution of diagnoses. In a recent national survey of all general practitioners, around 76% of the GPs reported the use of national sickness guidelines. Nearly, two-thirds of the GPs reported that

the guidelines had facilitated their contacts with patients and one-third with social insurance officers, other healthcare staff and employers (Skaner *et al.*, 2011).

6 It is not easy to estimate the average caseload for caseworkers as statistics on the number of registered unemployed with mental health problems are not readily available. But using the data shown in Figure 4.5, it is reasonable to estimate that around 25% of the 678 000 jobseekers registered at the PES in 2010 suffer from a mental disorder.

7. For example, in Denmark, caseworkers working in the special return to work programme for clients with common mental disorders have a caseload of around ten (OECD, 2013).

8. Development Employment is an initiative focussing on adapting work for jobseekers with functional disabilities and offers a wage subsidy to employers for up to a maximum of one year. Similarly, Security Employment offers financial support in the form of a wage subsidy to employers but for persons with severe illnesses. Under the Public Sheltered Employment programme, grants are available to public-sector employers who arrange sheltered employment. Samhall is a state-owned enterprise that provides work for persons with functional disability whose need for an adjusted work situation cannot be met in any other way. Activities are funded by state subsidies.

9. Note that, since data does not distinguish between moderate and severe disorders, it is difficult to comment which programmes are the most effective for those with mild to moderate disorders.

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# *Chapter 5*

# Integrating mental health and employment services in Sweden

*This chapter discusses the effectiveness of the mental health system in providing adequate treatment to persons with common mental disorders, subsequently looking at the resource capacity in primary health care services, treatment options and the accessibility of specialist mental health care services. It then reviews the recent policy initiatives to improve co-ordination between the mental health and the employment system and the extent to which rehabilitation services are offered in an integrated way.*

Most persons with mild mental illness can recover well, provided they receive appropriate on-going treatment and support. Adequate treatment can enable persons with mental disorders to lead fulfilling lives as well as increase their chances to stay in, or return to, work. This in turn, can lift the very high burden of mental disorders on the individual and the economy. Yet, lack of treatment of mental health disorders remains one of the biggest barriers to achieving both good clinical and employment outcomes.

Additionally, the limited attention given to employment in the treatment process minimises the chances of gaining or returning to work. In Sweden, the interface between the employment and the health sector has improved over the past few years mainly due to the government's plan to cut down the very high sickness absence rates in the country. But actions need to go beyond this short-term objective. Poor co-ordination both within the mental health system and between mental health services and employment services continues to be a major obstacle for effective rehabilitation and recovery.

## Treatment, access and utilisation of mental health services

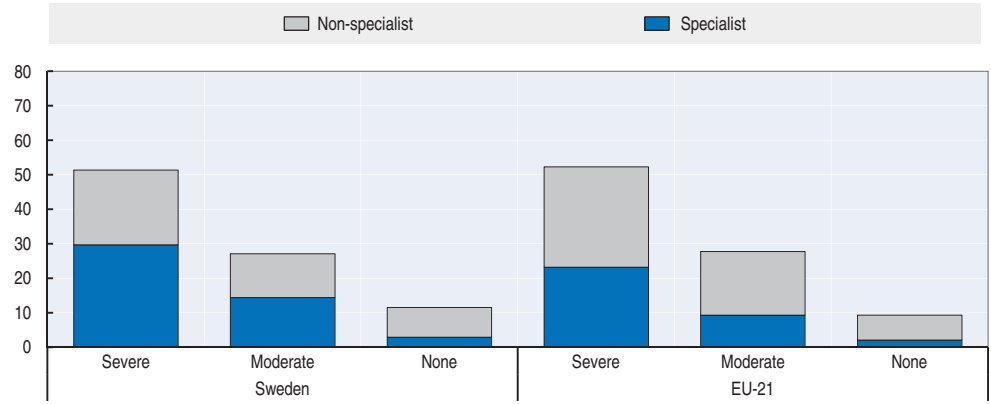
### *The treatment gap for mental disorders is large*

Most people who are severely mentally ill are likely to be known to the mental health service or have had some earlier contact with the mental health system. Survey-based evidence on the current use of mental health care (drawing on the Eurobarometer), however, suggests that under-treatment is large: some 50% of those with a severe mental disorder and over 70% of those with a moderate mental disorder do not receive any treatment for their illness (Figure 5.1). This suggests a large unmet potential need for mental health services in Sweden, as in other OECD countries. Moreover, treatment is often only given by a general practitioner, not involving any specialist, thereby lowering the chances for the patient to receive adequate treatment in line with minimum treatment guidelines. In an international comparison it appears though that Swedes are more likely than people in other countries to receive treatment by a specialist health care professional such as a psychiatrist.

The under-treatment of persons with moderate mental disorders in Sweden, as in other OECD countries, remains a big challenge. This is likely to have negative consequences for the individual and the society. If left untreated, milder disorders may transform into serious ones over time affecting an individual's chances of functioning as well as increasing their risk of resorting to sickness and disability benefits that generate a huge cost to the economy.

Figure 5.1. **Under-treatment is potentially very large**

Proportion of people being treated by a specialist or non-specialist, by severity of their mental disorder, mid-2000s




*Source*: OECD calculations based on the Eurobarometer, 2010.

### *The current potential of reducing the treatment gap in primary care is weak*

Many psychiatric disorders are either preventable or manageable through proper prevention or primary care interventions. Better management of these chronic conditions in primary care settings can reduce exacerbation and costly hospitalisation. In addition, discrimination and stigma are reduced because people with mental disorders are treated in the same way as people with other conditions (WHO, 2008).

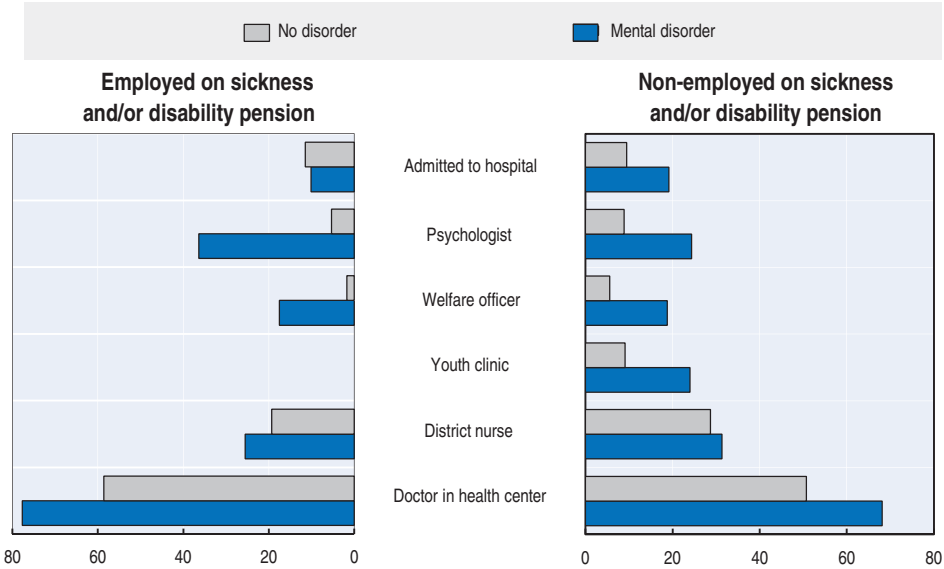
In Sweden, according to the Health Act, the responsibility for patients with mild to moderate mental health problems lies with the primary care sector, as with patients with physical health problems who do not require hospitalisation. On the other hand, patients with severe mental health problems are referred on to specialised psychiatric care in hospitals. Unlike in other OECD countries, GPs are not the main gatekeepers into specialist mental health care and services. In most of the Swedish counties, it is possible to bypass primary care and access specialist services directly.

The latest survey on public health shows that, a substantial proportion of persons with an identified mental disorder have contact with their doctors in the health centres. Persons with a mental disorder have significantly more contact with their GP than with any other profession (Figure 5.2). For example, some 70% to 80% of those on sick leave and disability benefits are in contact with their doctor in primary health care.

This represents a substantial opportunity for early identification of mental disorders, treatment of common mental disorders, as well as paying attention to the mental health needs of people with physical health problems. High over-representation of those on sick leave in particular lends to improving mental health services in primary health care units as they are at a high risk of leaving the labour market if no medical treatment is offered.

Figure 5.2. **Primary care has a main role to play in treatment of mental illness**

Share of persons who visited a doctor, by type of practitioner, labour force status and mental disorder




*Source*: Swedish Health Interview Survey, 2009-11.

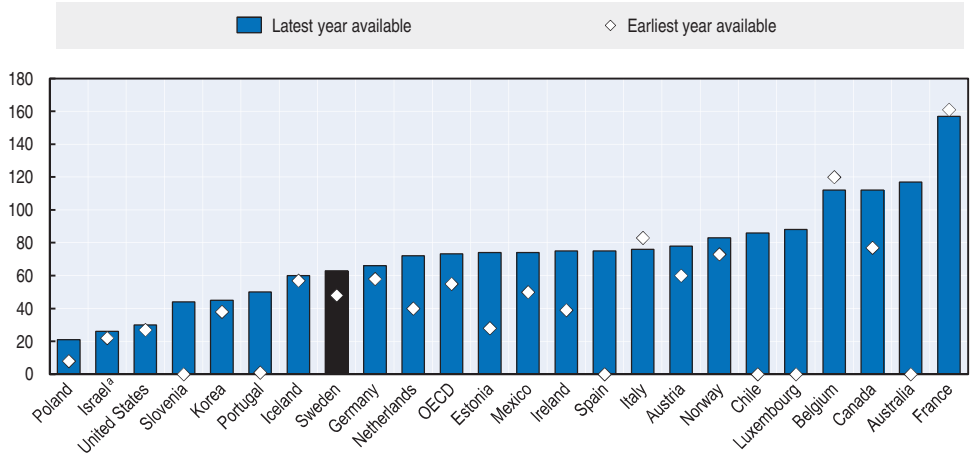
Despite these potential benefits of providing mental health services in the primary care setting, Swedish GPs, as in other OECD countries, are often unable to fully understand and treat their patients' mental health concerns. This is partly due to time constraints and a lack of psychiatric training, leaving the physician unable to address much beyond the patient's physical complaint.[1]

An adequate and well-trained health workforce in primary health care settings is a prerequisite for quality front-line services. Currently, although the bulk of the burden of treating persons with mild mental disorders falls on physicians, the workforce in the primary care sector is relatively small to respond to such needs. Indeed, the density of GPs per 1 000 inhabitants lags behind the OECD average (Figure 5.3). The relatively low number of GPs is

likely to undermine the effectiveness of prevention, diagnosis and treatment of illness and may further exacerbate the delay in receiving treatment. Lack of access to treatment and long waiting times has a number of repercussions on the welfare system. For example, according to Engblom *et al.,* (2011), a majority (63%) of the GPs certified unnecessarily long sick leave periods at least once a month due to waiting times for investigations or medical treatments. One third did this due to lack of access to cognitive behavioural therapy for patients. Another third did so due to lack of other adequate treatment or care providers.

Figure 5.3. **Sweden has fewer GPs than most other OECD countries**

Density of general practitioners, earliest and latest year available, per 100 000 population




*Note*: OECD is an unweighted average of the countries in the chart.

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

*Source:* OECD Health Care Quality Indicators Data 2012 *(www.oecd.org/health/healthdata).*

Lacking data on treatment in out-patient clinics mean that evaluations on how effective primary health care performs in dealing with mental health problems are largely missing. Available indicators by the Swedish National Health and Welfare Board provide some indication on efficiency.[2] The indicator "avoidable inpatient medical care for people with a psychiatric diagnosis" reflects the quality of outpatient care, such as primary care and preventive public health efforts, for certain specific conditions. The assumption is that unnecessary hospitalisations can be avoided if patients with the selected conditions receive proper outpatient medical care.

According to the report on Quality and Efficiency in Swedish Health care in 2010, the percentage of avoidable admissions was considerably higher among people who had been treated for psychiatric diagnoses. Among the reasons may be that the medical condition was detected later or treatment took longer. But it could also mean that patients were not good at complying with their regimens.

In an effort to support doctors in primary care units in dealing with psychiatric disorders, the NBHW has issued clinical guidelines for depression and schizophrenia. It also recommends evidence-based psychological treatment options for such disorders. Among all the treatments, cognitive behavioural therapy (CBT) is ranked highly in the case of all mild and moderately serious states of mood and anxiety disorders. However, most GPs have inadequate training for giving CBT and thus accessing this service from primary care is difficult and can involve long waiting times. New cost-effective ways are sought of improving access to CBT in Sweden which might remedy the situation (Box 5.1).

Box 5.1. **Innovative practice for delivering cognitive behavioural therapy for mild and moderate mental disorders**

A number of scientific evaluations have shown that CBT is an effective treatment for both panic disorder and depressions as well as effective in increasing persons return to work provided it is delivered through trained experts. In response to the lack of psychologists and psychotherapists that use CBT methods, Internet-based CBT has been developed, in which the patient undergoes an Internet-based self-help programme and has contact with a therapist by email.

Results so far show promising results. For instance, a randomised clinical trial of 104 patients with panic disorder compared the effectiveness of Internet-based CBT and group CBT within a regular healthcare service. The study shows that both treatments worked very well and that there was no significant difference between them, either immediately after treatment or at a six-month follow-up. Analyses of the results for the treatment of depression show that Internet-based CBT is most effective if it is administered as early as possible. Patients with a higher severity of depression and/or a history of more frequent depressive episodes benefited less well from the Internet treatment. Internet treatment had also superior cost-effectiveness ratios in relation to group treatment both at post-treatment and follow-up (Bergström *et al.,* 2010).

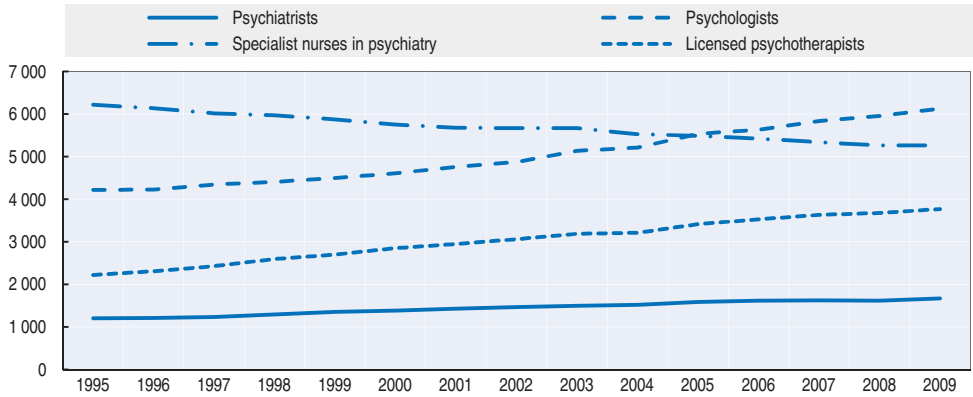
### *Overall supply of specialist mental health staff is insufficient*

Similar to the primary sector, Sweden is facing considerable shortages in specialised personnel, especially in the area of clinical psychology and other specialist staff well placed to deliver adequate treatment.

Figure 5.4 presents the overall picture of specialist staff in psychiatry. The number of psychiatrists has been systematically lower than that of any other specialist staff category. During the period 1995-2009, the availability of psychiatric nurses has declined steadily while the number of licensed psychotherapists and psychologists has been rising. Nevertheless, by international standards, the availability of psychiatrists (as measured by the density of psychiatrists per 100 000 inhabitants) in Sweden is above the OECD average. On average, there are around 20 psychiatrists available per 100 000 inhabitants. But there are significant variations regarding the distribution of psychiatrists between the counties and regions. According to the national health report on psychiatric care, the number of psychiatrists per 100 000 inhabitants is too low (NBHW, 2010).

Figure 5.4. **The number of non-medical specialists is increasing while there are fewer specialist nurses**

Employees in psychiatry for health sector by occupation




*Note*: Includes all persons working in the private and public health care sector.

*Source*: NBHW (2010), *Psykiatrisk Vard – ett steg på vägen* (Psychiatric Treatment – A Step on the Way), National Board of Health and Welfare, Stockholm.

In some regions, with a shortage of salaried psychiatrists, county councils are forced to employ psychiatrists, either independently working doctors or supplied by private medical staffing companies as "rent-a-doctor" at relatively exorbitant rates. As such, the system has become much more expensive for the public, and discontinuous, so that patients tend to meet a new doctor at each return visit with little follow-up. In effect, there is a vicious circle whereby psychiatric clinics function badly because of a doctor shortage and rented doctor discontinuity, while the resulting stressful

working conditions serve to discourage young doctors from choosing psychiatry as a profession.

There is a growing concern about the financial untenability of such a solution. According to the New Action Plan on Mental Health, the government plans to increase the number of training places in the psychology programme and create research posts in psychiatry.

Patients seeking treatment can also directly make contact with outpatient clinics in the private sector that are affiliated to the public health care system at reduced costs.[3] With regards to psychologists, psychiatrists and psychotherapists, there are also private practices without affiliation to the public system. This, however, is a more expensive alternative and unaffordable for many patients.

Though having access to a psychiatrist in the government-funded part of the private sector can facilitate faster access to treatment, such psychiatrists are relatively few, and almost exclusively concentrated in the larger cities. Anecdotal evidence suggests that with the current tendency towards the privatisation of health care, a restrictive policy within the county councils has made it difficult or impossible for doctors working on their own (regardless of speciality), to be registered as private practitioners within the national health system. This may further exacerbate lack of treatment among patients with lower socio-economic backgrounds who cannot afford to purchase treatment in the private sector.

The current two-tier system of GPs and specialists in the public and the private sector is problematic particularly for persons with mild mental disorders who appear to be functional in daily lives despite having a disorder, yet live in states of suffering which demand expert and time consuming treatment. Many of these patients are not favoured by public psychiatry as they would simply not qualify as “sick enough” and instead be advised to seek expensive private help.

## The health and employment interface

Traditionally, as in most other OECD countries, focus on employment matters in the mental health system has been very limited. But this in Sweden is changing. The health care sector has now an increased responsibility as a partner, who is obliged to be more actively involved in the sick listing and rehabilitation process. Yet, work and employment are not yet seen as a primary goal or a means of treatment by the mental health system.

The following section reviews some of the major policy initiatives undertaken in the last few years to better align objectives and services to achieve better socio-economic outcomes for persons with mental health problems.

### *Policies addressing employment in the mental health system are developing slowly*

In the mental health sector, the importance of work or the adverse consequences of being out of work have been recognised in two main ways. First, the latest national strategy for mental health *(2009-11) – From Vision to Action* – aimed at strengthening psychiatric care – highlights that the "work-first" principle also applies for persons with mental health problems.[4] Accordingly, the plan calls for greater attention to work and occupational therapy in municipalities.

Second, the National Board of Health and Welfare has taken a number of initiatives mainly in accordance with the government's overarching goal of reducing sickness absence. Consequently, as mentioned earlier, the board published diagnostic-based sickness absence guidelines for GPs issuing sickness certificates. It also recommends the Individual Placement and Support (IPS) model for persons with schizophrenia or schizophrenia spectrum disorders and indeed, a number of IPS pilots across Sweden are currently in place. Evidence indicates that IPS-supported employment is a more effective approach for helping people with psychiatric disorders to find and maintain competitive employment than traditional, stepwise approaches to vocational rehabilitation.

These initiatives represent an important step but there is a need for more focused action to include work as a means to achieve better clinical and employment outcomes. For example, though the Action plan emphasises work as part of a holistic treatment strategy, it does not provide direction as to who is responsible for what nor does it include clear tangible objectives in regards to employment. Similarly, in spite of collecting substantial information on evidence based treatment, the NBHW does little dissemination and promotion of work in its guidelines.

### *Financial incentives for health and medical care*

More recently, collaboration between the employment and the health sector is reinforced through financial co-operation, specifically targeting those with mental health problems. The Ministry of Health and Social Affairs recently introduced a *Rehabilitation Guarantee* for people on sick leave or at risk of longer-term leave as a result of long-standing psychological problems such as anxiety, depression or stress, whereby county councils are receiving direct payment from the SSIA for each medical intervention. The guarantee offers rehabilitation measures in the form of cognitive behavioural therapy (CBT) and interpersonal psychotherapy for a relatively short period. Those working with CBT must be qualified, and assessment and treatment can take place either individually

or in groups. The Rehabilitation Guaranty includes such medical treatments which have proven beneficial in the process of returning to work.

The outcomes of the Rehabilitation Guarantee have improved over time due to improved local implementation process and the development of interventions, but there still seem to be significant weaknesses in the scheme. Two cohorts were followed-up; one in 2009 and another in 2010 to examine the effects of the Rehabilitation Guarantee on sickness absence and health. According to the evaluation by Karolinska Institute, the pattern of sick leave was similar regardless of whether a person obtained therapy via the Rehabilitation Guarantee or not. However, results from the 2010 cohort showed a statistically significant difference between the treatment group and the reference group in terms of the proportion that was granted disability pension. The latter had an approximately 170 percentages higher risk of receiving a disability pension. Individuals who received rehabilitation covered by the guarantee also experienced improvements in their mental and physical health and their ability to work during the follow-up period (Karolinska Institutet, 2011a and 2011b).

The full potential of the scheme is however, yet to be harvested. According to the authors, several factors undermine the effectiveness of the scheme. For instance, it is argued that six sessions are too few in the context of rehabilitation. Another concern is the high early dropout rate before the treatment ends. For example, data from one county council (Skåne) indicate that roughly 34% of those who had started the programme terminated treatment within six rehabilitation sessions. Furthermore, authors found that early drop-out and the low number of patients at many units (less than five patients per year) in general made it financially unviable for primary care units to deliver "highly qualified" rehabilitation service. This in turn affected motivation to develop the guarantee within the unit as well as to maintain specialist competence.[5]

In theory, extra funding provided by the SSIA for the health sector to boost psychological treatment indicates a concrete step towards integrating treatment and mental health. However, the success of the scheme is also dependent on the ability of the health sector to provide a sufficient number of staff with competence to deliver specialist therapies. The Rehabilitation Guarantee currently faces immense challenges as there is a lack of people with adequate training in CBT (as discussed above). There is a definite need for new recruitment of people with those skills, but funding is still lacking.

### *Divided responsibility for rehabilitation can hinder rapid return to work*

Persons with psychological disorders often suffer from a combination of medical, social and work-related problems and therefore are in need of a comprehensive rehabilitation approach to facilitate early recovery and successful return to work.[6] As such, co-operation in rehabilitation between different actors is imperative. However, the existing institutional structure of a split level of governance of health and social services means that it is difficult to provide co-ordinated and good quality care for people with mental health problems.

Responsibility for providing health care and social services to people suffering from mental illness is divided between the government and the municipal and county councils. The municipalities running social services bear primary responsibility for the provision of housing and occupational therapy to people with mental health problems. Psychiatric treatment, on the other hand, is part of health and medical care of the county councils.

Currently, there is a lack of formal mechanisms for co-operation between the national, the regional and the local level and thus integration of health and employment services remains a big challenge for both health and social services. Too often, rehabilitation measures do not reach their intended target or lead to undesired effects since it is not clear who will pay for rehabilitation; intervention is often coming too late due to the conflicting priorities of different actors.

For some time, Sweden has been trying to tackle this issue by enticing co-operation through pooling together funding under the 2004 Act on Financial Co-ordination and Rehabilitation Measures, which allowed different institutions in the rehabilitation field to form local associations for financial co-ordination.[7] This co-operation involves the SSIA, health and medical services, the social services and the PES. Under the Act, the parties are required to contribute in equal amounts but contributions are not earmarked for interventions coming under any one party's sphere of responsibility. So far, a total of 80 co-ordination associations representing some 200 municipalities have been established. The main target group for financial co-ordination would in general include those who need integrated efforts *i.e.* long-term unemployed, long-term sick leave recipients and young persons. Activities under these associations usually related to occupational and labour market measures, socio-medical and preventative and promotional measures.

Though, practice in different associations vary, the model hinges upon multidisciplinary teams, consisting of physicians, psychologists, social workers and employment officers who provide the above stated services. By

way of example, DELTA – one of the earliest and long-running co-operations in the region of Gothenburg – offers co-ordinated services to clients in need of rehabilitation. The main objective of early and co-ordinated rehabilitation programmes under DELTA are *i)* social medical activities included in a treatment plan to shorten patient treatment, *ii)* occupational activities to speed up return to work, and *iii)* preventative activities aiming to prevent sickness absence and social exclusion (Box 5.2 for more details).

Evaluations of such co-operation models are limited. DELTA is the only collaborative model that has been systematically evaluated over time. Most of the studies show mixed results and very few of them have evaluated the impact of co-operation on return to work. Ahgren *et al.* (2009), report that users perceive services as well integrated and adapted to their needs. Results from a follow-up study in 2005 also showed that interventions under DELTA had a positive impact on finding employment. Some eight out of ten formerly unemployed were able to maintain gainful employment, while two out of three were no longer sick-listed (Wollberg, 2006).

Other evaluations, however, are more critical. Andersson *et al.* (2011), for instance, argue that among all the different types of approaches, pooling of budgets is the most complex and demanding model of collaboration in vocational rehabilitation. Lack of employer involvement in facilitating return to work is a major obstacle to better outcomes. Furthermore, a more recent study showed that, the recent changes in the sick leave process *i.e.* work capacity assessments at three and six months periods have led to a more narrow time perspective which puts higher demands on purposeful co-operation between relevant actors in the processes of rehabilitation and return-to-work (Ståhl *et al.,* 2011).

The approach to generate co-operation through pooling of budgets has had some positive impact on providing integrated rehabilitation services, but has a number of drawbacks. One major issue is that financial co-ordination is solely voluntary. This does not guarantee sustained collaboration in the long-run nor effective follow-up of individuals who need the greatest support. Secondly, though the principle idea of offering services through "one-stop-shop" like models (such as the model offered by DELTA) are desirable, many of the initiatives are free-standing projects as opposed to forming an integral part of an authority's regular operations. As such, a more systematic national or municipal-led approach is required to provide uniform services.

### Box 5.2. **Innovative model of co-operation between the employment and the health sector**

DELTA was launched in 2007 in Hisingen, as one of the six areas hosting pilot projects on financial co-ordination involving the social insurance authorities, the health and medical care services and the social services. The pilot intended to support individuals and cut costs arising in connection with absence from work due to illness, unemployment and other welfare benefits.

Just over 25 activities have been carried out within DELTA since its inception in 1997. Current activities can be categorised under three main headings: *i)* preventative and promotional activities, *ii)* socio-medical activities and *iii)* occupation activities.

**Working methods and activities**

Preventative and promotional activities are targeted at preventing absences due to illness and tackling social exclusion. Working methods include interviews and discussions with clients; theme based sessions, group activities as well as dissemination of information and education.

The main aim of the socio-medical activities is to reduce waiting times and shorten patient treatment and speed up return to work. Measures are conducted by inter-professional teams in primary health care centres and the treatments on offer are adapted to the needs of the clients. All activities offer early intervention with the aim to cutting down rate of absence from work due to illness.

Occupational measures are orientated towards attaining employment. One example of the occupational activity is the labour market Plaza. The plaza operates as a one-stop-shop providing a range of services for clients who previously were shunted from one authority to another.

Collaborative primary health care centres are open to anyone in need of inter-professional interventions. There are also special initiatives targeted at young persons with mental health problems (mainly those who have not finished high school education) registered with the PES or those in receipt of social assistance.

Each client has a joint action plan which is designed jointly by the different authorities. A number of hours per week are set aside to discuss and agree on issues relating to individuals cases.

DELTA based activity is assigned a project co-ordinator, a number of project assistants and a steering committee. Project co-ordinators are usually recruited and paid from one of the collaborating authorities, *e.g.* SSIA, PES, etc.

Other ways of ensuring co-operation should be sought to give each actor, or government level, the right (financial) incentive to act in a way that improves outcomes – including employment outcomes – overall and not only within the area of responsibility of the respective actor. An alternative approach of integrating health and employment objectives is through

building employment capacity within the health sector and *vice versa*. One interesting example is the pilot *Individual Access to Psychological Therapies* (IAPT) in the United Kingdom, whereby co-location of Employment Advisers' with clinical teams has been successfully exploited to advocate an early intervention approach to job retention support. Employment Advisers are part of the IAPT service provision and play a key role in contributing to multi-disciplinary delivery. This duality of approach has been critical to the success of the pilot, as close working with IAPT colleagues in the Primary Care team ensured that service users had their employment and their mental health needs met at the same time and by the same team.

## Conclusion and recommendations

As in other OECD countries, mental disorders are under-treated in Sweden. Less than a third of those who suffer from a mild mental disorder and around a half of those with a severe mental disorder receive treatment which is critical for fostering early recovery and facilitating early return to work.

GPs in the primary care setting frequently encounter mild mental disorders. Up to 80-90% of those on sick leave with mental disorders are in contact with their GP. But Swedish GPs in primary care have insufficient training and resources to deal with prevailing mental health issues among their patients. Primary mental health care is only now beginning to expand as a result of recent initiatives to provide psychological therapies, but these efforts are likely to be insufficient in closing the large treatment gap. Better training is needed for GPs for them to deliver short-term cognitive behavioural therapy. Similarly, more resources need to be diverted to train and recruit psychiatrists and psychologists to meet the growing demand of psychotherapy treatment.

The interface between the employment and the mental health sector has improved in the past few years in the context of reducing the huge number of persons on sickness and disability benefits. That said, Sweden still lags behind in promoting employment issues in the mental health system. Too few people who use mental health services are supported to achieve their employment aspirations. On the one hand, increasing co-operation between the mental health system and the sickness insurance through the Rehabilitation Guarantee should be praised but initial results are still disappointing. On the other hand, co-operation between the PES, SSIA and the mental health service in terms of rehabilitation measures, which is critical in facilitating early return to work, is inadequate. Current approaches

of pooling budgets to integrate rehabilitation measures have not delivered the desired outcomes.

### *Strengthen capacity of the mental health system*

- *Increase capacity in primary care to better identify and treat persons with mental disorders.* Give mandatory training to GPs on CBT as well as refresher courses on identifying mental health problems for those who have been in practice for a long time. At the same time, increase the number of psychotherapists and psychiatrists working in primary health care units whereby GPs can make quick and easy referrals within the same health practice. In addition, NBHW should develop indicators using the patient register dataset to monitor the effectiveness of diagnosing and treating moderate mental disorders in the primary care sector.
- *Increasing resources to train more psychotherapists, psychiatrists and special psychiatric nurses.* One way of achieving this could be to offer higher salaries to attract more persons in this profession.

### *Improve integration between health and employment policy*

- *National Action plan on mental health should include employment outcomes.* Include common agreed goals and measures on employment into the Action Plan on mental health with systematic follow-up and monitoring of goals. This would foster the notion that work is a key element in treatment of mental illness.
- *Disseminate and promote evidence-based treatment for return to work.* In addition to providing evidence-based guidelines on treatment, NBHW should promote treatment that is effective for return to work among GPs and other mental health professions. The board should also disseminate good practice co-operation models between local employment and health services.
- *Build-in outcome-based payments in the Rehabilitation Guarantee.* Consider a move towards an outcome-based funding model which could facilitate innovation and change in the current Rehabilitation Guarantee. Fees should be paid on the number of beneficiaries of sickness benefit treated by the health care sector.
- *Integrate vocational and clinical services*. Integration of vocational and clinical services is key to higher employment of persons with mental disorders. Integration other than pooling of funds can be achieved in several ways. One approach is that the health system

builds vocational capacity within its own realm- as is done in England where the IAPT model is funded by the National Health Service. Alternatively, the employment services or the SSIA can build clinical capacity by hiring mental health specialists.

## *Notes*

1. A three month psychiatry rotation after medical finals is mandatory within the two-year housemanship period leading to basic medical qualification. Qualified doctors embarking on the 5-6 year specialist training to become GPs (in Sweden general practice is considered a speciality), are currently not legally obliged to complete a further rotation within psychiatry. It is however legally necessary to prove sufficient knowledge of psychiatry to the supervisor. Thus, current praxis considers it highly desirable that trainee GPs gain at least four months of additional psychiatric experience during specialist training, mainly in out-patient units, unless they can prove to their supervisor that they have previously acquired this competence.
2. A total of 15 national indicators have been prepared for the follow-up of the health care (psychiatric) inputs and 12 national indicators for social service inputs for persons with mental impairment. These indicators mostly cover population suffering from severe mental illnesses.
3. Specialist doctors registered with the public system are reimbursed by the state medical system known as the National Tariff for Medical Specialists (*nationella läkarvårdstaxan).*
4. Four priority areas include; children and young people, access to work for people with psychiatric diseases or disabilities, the development of evidence and skills and quality development. A large number of decisions regarding assignments have been made in these areas.
5. A health care clinic receives a start-up fee to start up patient treatment, but the clinic receives little or no compensation from the county council if there is an early drop-out of treatment.
6. Rehabilitation is a collective term for interventions of a medical, social, psychological and occupational character aimed at restoring an individual's ability to function, work and lead a normal life.
7. Between 1993 and 2003, there were a number of initiatives for improving inter-organisational co-operation in rehabilitation. These experiments resulted in a new legislation in 2003.

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OECD PUBLISHING, 2, rue André-Pascal, 75775 PARIS CEDEX 16
(81 2013 07 1 P) ISBN 978-92-64-18870-9 – No. 60429 2013-05

# Mental Health and Work

# SWEDEN

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## Further reading

*Sick on the Job? Myths and Realities about Mental Health and Work* (2012)
*Mental Health and Work: Belgium* (2013)
*Mental Health and Work: Denmark* (2013)
*Mental Health and Work: Norway* (2013)

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Please cite this publication as:
OECD (2013), *Mental Health and Work: Sweden*, OECD Publishing.
***http://dx.doi.org/10.1787/9789264188730-en***

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**ISBN 978-92-64-18870-9**
**81 2013 07 1 P**

9 789264 188709