

OECD Social, Employment and Migration Working Papers
No. 161

Mental Health and Work: Achieving Well-integrated Policies and Service Delivery

Iris Arends,
Niklas Baer,
Veerle Miranda,
Christopher Prinz,
Shruti Singh

https://dx.doi.org/10.1787/5jxsvvn6pq6g-en

OECD

For Official Use **DELSA/ELSA/WD/SEM(2014)7**

Organisation de Coopération et de Développement Économiques
Organisation for Economic Co-operation and Development

English - Or. English

DIRECTORATE FOR EMPLOYMENT, LABOUR AND SOCIAL AFFAIRS
EMPLOYMENT, LABOUR AND SOCIAL AFFAIRS COMMITTEE

DELSA/ELSA/WD/SEM(2014)7
For Official Use

OECD SOCIAL, EMPLOYMENT AND MIGRATION WORKING PAPERS No. 161

MENTAL HEALTH AND WORK: ACHIEVING WELL-INTEGRATED POLICIES AND SERVICE DELIVERY

Iris Arends (UMCG/University of Groningen, Netherlands), Niklas Baer (PBL: Psychiatrie Baselland, Switzerland), Veerle Miranda (OECD), Christopher Prinz (OECD), Shruti Singh (OECD)*.

JEL Codes: I18, I28, I38, J18, J28

** This work has benefited from the financial support of the Dutch Ministry of Social Affairs and Employment*

Authorised for publication by Stefano Scarpetta, Director, Directorate for Employment, Labour and Social Affairs.

For further information, please contact: Christopher Prinz (christopher.prinz@oecd.org, +33 1 45 24 94 83). All Social, Employment and Migration Working Papers are available on www.oecd.org/els/workingpapers.

Complete document available on OLIS in its original format
This document and any map included herein are without prejudice to the status of or sovereignty over any territory, to the delimitation of international frontiers and boundaries and to the name of any territory, city or area.

English - Or. English

DIRECTORATE FOR EMPLOYMENT, LABOUR AND SOCIAL AFFAIRS

www.oecd.org/els

OECD SOCIAL, EMPLOYMENT AND MIGRATION WORKING PAPERS

www.oecd.org/els/workingpapers

OECD Working Papers should not be reported as representing the official views of the OECD or of its member countries. The opinions expressed and arguments employed are those of the author(s).

Working Papers describe preliminary results or research in progress by the author(s) and are published to stimulate discussion on a broad range of issues on which the OECD works. Comments on Working Papers are welcomed, and may be sent to the Directorate for Employment, Labour and Social Affairs OECD, 2 rue André-Pascal, 75775 Paris Cedex 16, France.

This series is designed to make available to a wider readership selected labour market, social policy and migration studies prepared for use within the OECD. Authorship is usually collective, but principal writers are named. The papers are generally available only in their original language – English or French – with a summary in the other.

Applications for permission to reproduce or translate all or part of this material should be made to:

Head of Publications Service
OECD
2, rue André-Pascal
75775 Paris, CEDEX 16
France

Copyright OECD 2014

ABSTRACT

Mental ill-health can lead to poor work performance, high sickness absence and reduced labour market participation, resulting in considerable costs for society. Improving labour market participation of people with mental health problems requires well-integrated policies and services across the education, employment, health and social sectors. This paper provides examples of policy initiatives from 10 OECD countries for integrated services. Outcomes and strengths and weaknesses of the policy initiatives are presented, resulting in the following main conclusions for future integrated mental health and work policies and services:

- More rigorous implementation and evaluation of integrated policies is necessary to improve labour market outcomes. Implementation cannot be left to the discretion of stakeholders only.

- Better financial incentives and clearer obligations and guidelines need to be provided to stakeholders and professionals to participate in integrated service delivery.

- Each sector has a responsibility to assure integrated services in line with client needs, in turn requiring much better knowledge about the needs of clients with a mental illness.

- More integrated provision of services *within* each sector – e.g. through employment advice brought into the mental health system and psychological expertise brought into employment services – appears to be the easiest and most cost-effective approach.

RÉSUMÉ

La mauvaise santé mentale peut conduire à une moindre performance au travail, une forte incidence de l'absentéisme pour maladie et un taux d'activité réduit, ce qui entraîne des coûts considérables pour la société. Améliorer la participation sur le marché du travail des personnes ayant des troubles mentaux exige des politiques et des services intégrés dans les domaines de l'éducation, l'emploi, la santé et les secteurs sociaux. Ce rapport propose des exemples d'initiatives politiques provenant de 10 pays de l'OCDE pour des services intégrées et présente leurs résultats ainsi que les points forts et les faiblesses. Les principales conclusions pour l'avenir des politiques et des services intégrés dans les domaines de santé mentale et de l'emploi sont les suivantes:

- Une mise en œuvre et une évaluation plus rigoureuse des politiques intégrées sont nécessaires pour améliorer les résultats du marché du travail. La mise en œuvre ne peut pas être laissée à la discrétion des parties concernés seulement.

- Le renforcement des incitations financières et des obligations et des lignes directrices plus claires doivent être fournis aux parties concernés et aux professionnels pour participer à la prestation de services intégrés.

- Chaque secteur a la responsabilité d'assurer des services intégrés en fonction des besoins des clients, ce qui exige à son tour une meilleure connaissance des besoins des clients avec des troubles mentaux.

- Plus de prestations de services intégrés au sein de chaque secteur – par exemple des conseils de l'emploi incorporés dans le système de santé mentale et de l'expertise psychologique incorporé dans les services de l'emploi – semble être l'approche la plus simple et la plus rentable.

TABLE OF CONTENTS

ABSTRACT 3

RÉSUMÉ 3

TABLE OF CONTENTS 4

PART ONE 5
TOWARDS INTEGRATED MENTAL HEALTH AND EMPLOYMENT SERVICES 5
- High costs in all sectors call for integrated policies and services 5
- Integrated services are slowly spreading 6
- Implementation is lagging behind aspiration 9
- Rigorous evaluation is rare 9
- Adequate knowledge and incentives for the key actors 10
- Finding the best way to organise integrated services 11

PART TWO 13
LEARNING FROM PROMISING POLICIES ACROSS OECD COUNTRIES 13
- Defining “integrated services” 13
- Linkages between sectors and services 14
- Co-ordination of services 19
- Provision of fully integrated services 24

REFERENCES 31

PART ONE

TOWARDS INTEGRATED MENTAL HEALTH AND EMPLOYMENT SERVICES

High costs in all sectors call for integrated policies and services

1. Mental ill-health is widespread and creates large social and economic costs.[1] Conservative estimates suggest that the total cost to society reaches around 3-4% of a country's gross domestic product (Gustavsson et al., 2011). The costs of mental ill-health are not restricted to the health care system but affect the economy more broadly and especially the labour market and the welfare system. Direct medical costs account for around one-third of the total costs, while more than half of the costs are related to welfare benefits, lost employment and reduced productivity at work (Gustavsson et al., 2011; Stansfeld, Fuhrer and Head, 2011; Rai et al., 2010).

2. Policy is not responding adequately and sufficiently to the high costs that mental ill-health generates in the labour market and the welfare system. Mental health issues are often a main barrier to finding and keeping a job. For instance, people with a mental disorder are twice as likely to be unemployed than those without a mental disorder and among those who are unemployed, between one-third and one-half struggles with a mental illness (OECD, 2012). The employment sector alone cannot solve this problem, nor can the mental health sector.[2] Both sectors need to address this issue jointly, especially because investments in one sector would also and often benefit the other.[3]

3. In most countries, the mental health and employment sectors operate independently of each other, with different objectives and different approaches and often under different government authorities. Medical services aim to treat people and improve symptoms and daily life functioning, with very limited attention to employment and workplace issues. Employment services aim to reintegrate people into work through activation and training but do not address frequently occurring health issues of clients or wait until "cured" clients return from treatment. This type of arrangement of policies and services has a number of negative consequences. For instance, it gives rise to an incentive to shift people from one government service to another to reduce costs in one sector and to stay away from investments with returns in other sectors (OECD, forthcoming/a). It is also likely to result in only some of the needs of people with mental ill-health being met. This is an inefficient use of public resource and often causes disappointing social and employment outcomes.

---

1 . Mental disorder in this paper is defined as a clinically diagnosable disorder that significantly interferes with a person's cognitive, emotional and social abilities. The terms mental disorder, mental ill-health and mental illness are used interchangeably. At any point in time, around 20% of the working-age population suffers from a mental disorder in the clinical sense, most often a mild or moderate disorder ("common mental disorder"). Lifetime prevalence rates reach levels of 40-50%.

2 . The generic term "employment sector" in this paper refers to the delivery of employment services and the welfare system, the main actors within the sector therefore being the public employment service and the benefit or social insurance authority, but also occasionally employers. The term "mental health sector" refers to every medical service contributing to the treatment of mental illness, including primary care (general practitioners), other first-line mental health care (e.g. psychologists, specialised nurses and social workers) and specialist mental health care (psychiatrists but also hospitals).

3 . The same conclusion holds when looking at the education sector and the impact of mental ill-health on education outcomes. Also here, joint action by the mental health and the education sector is needed.

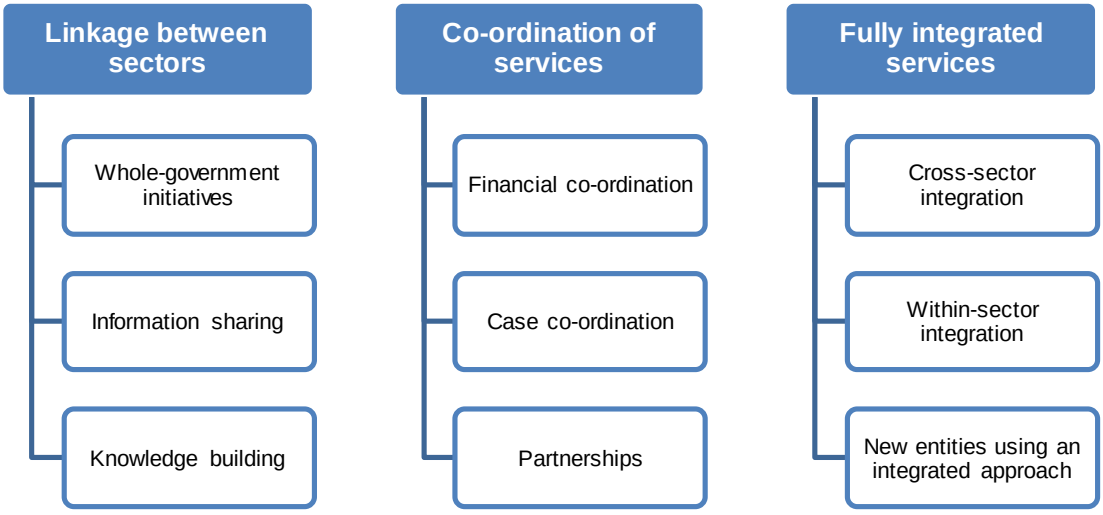
4. Better labour market outcomes will require bringing together policies and services and delivering simultaneous client-oriented supports from different institutions and professionals in different sectors. Aligning sectoral policy objectives – the objective of health services to improve functioning and well-being and the objective of employment services to keep people in work or help them find work – is a necessary first step. After all, these objectives are not that dissimilar, both aiming to improve the individual's ability to function in society. However, other challenges remain. Ensuring consistency between the various sometimes conflicting financial incentives for actors in different sectors is a bigger challenge as this can require changes in organisational structure and financing mechanisms. Aligning services vertically across different government layers is another challenge which will need strong leadership to allow for an all-of-government approach.

Integrated services are slowly spreading

5. The need for more integrated delivery of policies and services is increasingly felt by many stakeholders who are confronted with a large number of students, workers, clients and patients with mental health problems. There is also increasing evidence on the need for integrating services as research has shown that: i) employment is generally good for mental health and unemployment detrimental; ii) mental health treatment on its own does not improve employment outcomes; and iii) mental health treatment is more effective for patients who are employed.

6. Policy is slowly responding to these needs. Across the OECD countries, more and more initiatives are being undertaken to integrate mental health services with services in the field of employment, education, health and social policies. This paper identifies a number of innovative policy examples in the health, employment and education sectors in 10 OECD countries and presents these examples by the *intensity* of integration – ranging from lose links between services to fully integrated provision of services (Figure 1). Within each level of intensity different *types* of integration are distinguished.[4]

Figure 1. **A policy taxonomy: Levels and types of integration considered in this paper**



4. The taxonomy of levels and types of integration used in this paper differs somewhat from the classification used in a recent OECD report on integrated services for vulnerable population groups (OECD, forthcoming/a) which distinguishes colocation, collaboration and co-operation. In the future, if considered appropriate a harmonisation of the terminologies used might be sought.

7. The various policies, most of them introduced very recently, suggest that policy is changing in a number of different ways:

- Several countries are putting in place whole-government mental health initiatives and action plans, increasingly with attention to retaining and finding employment. More and more initiatives are found where information is shared across sectors and services. More efforts are also being made to draw on the knowledge in one sector in another sector (i.e. to improve knowledge of employment issues in the mental health sector and to improve knowledge of mental health issues in the employment sector). These initiatives to take a cross-disciplinary approach to dealing with mental health and work can be seen as both creating an awareness of the need and building the base for moving towards better integrated policies and services.

- Some countries have gone a step further in making services and policies more coherent. One way through which this is done is financial co-ordination, with sectors recognising the need for involving and paying for services from other sectors, without changing the practices of any of the sectors. Another way is through case co-ordination for clients with complex needs from different sectors, with a case-manager co-ordinating the services provided by different sectors, or through more binding cross-sector partnerships, with providers from different sectors meeting regularly to discuss the needs of a client. In all of these policies the aim is to assure the right service for a client, leaving operations within sectors untouched.

- A small number of countries are moving yet a step further towards providing truly integrated mental health and employment (or education) services alongside each other. In view of the financial barriers and disincentives, perhaps not surprisingly such initiatives have only been identified in two forms: i) more integrated services delivered *within* a sector through the creation of employment services in the health system and health services in the employment system; and ii) services delivered by a *new entity* specialised in integrated service provision (especially for young people). Both approaches circumvent difficult challenges that would arise if services were fully integrated across sectors.

8. The policy examples on integrated mental health and employment services and their strengths and weaknesses are described in detail in Part 2 of this paper. Table 1 summarises the examples provided in the paper and the page numbers on which more detail can be found.[5] In what follows, the key lessons arising from the country policies and analyses are discussed.

5 . The classification, based on levels and types of integration that have been identified in the literature (Andersson et al., 2011; Leutz, 1999), is solely used to facilitate the presentation of the country examples and should not be interpreted as a proposed model for integration. Country examples were classified based on their main characteristics but could sometimes well fit in different sections. The table does not intend to provide an exhaustive overview of all the programmes available in each country, but gives a selection of the most interesting examples from which other countries can learn.

Table 1. **Promising policy examples described in the paper**

	Linkage			Co-ordination			Full integration		
	Whole-government initiatives	***Information sharing***	***Knowledge building***	***Financial co-ordination***	***Case co-ordination***	***Partnership***	***Cross-sector integration***	***Within-sector integration***	***New entities***
AUS	Roadmap for mental health reform, *p.14*		Mental health skills training for GPs, *p.17**		Youth Connections: Case management for youth, *p.21*			Orygen: Employment services in a clinical department, *p.25*	Headspace: Multidisciplinary support for youth, *p.28*
AUT		Fit2work: Return-to-work support service, *p.15*		Health Road: PES and SSI pay for each other's services, *p.19*	Youth Coaching: Case management for youth, *p.21*				
BEL						PES programme combining care and employment support, *p.22*		Psychosocial prevention advisor for employers, *p.27*	Student guidance centres, *p.28*
CHE		Expanded medical certificate for employers, *p.15*	Employer counselling on health-related work problems, *p.18**			IIZ MAMAC: Co-operation between local authorities, *p.23*			
DNK		e-Health Clinical Database, *p.16**	e-training on mental health and job retention for GPs, *p.17** Tools for inspecting the PWE, *p.17*			Municipal rehabilitation teams, *p.23*		Employment centres including psychologists, *p.26*	
GBR	NHS Outcome Framework using employment outcome indicators, *p.14*							IAPT programme including employment advisors, *p.25*	Health and Work Service for return-to-work management, *p.29*
NLD		Covenant between mental health and employment institute, *p.15*	Practitioner guidelines to manage mental health and work, *p.17*		Return-to-work management by OPs, *p.20*			Mental health specialist supporting the GP, *p.24* E-health applications provided by PES, *p.27**	
NOR	Strategic plan for work and mental health, *p.14*		Employer support for health promotion, sick leave prevention, *p.18*						
SWE			Sickness certification guidelines for mental health problems, *p.16*	Rehabilitation guarantee: SSI pays for health treatment, *p.19* DELTA: A joint fund for different rehabilitation services, *p.20*					Youth Clinics: Multidisciplinary support for youth, *p.28*
USA								Individual Placement and Support (IPS), *p.25*	Employee Assistance Programme (EAP), *p.29*

NHS = National Health Service; GP = general practitioner; PWE = psychosocial work environment; PES = public employment service; SSI = social security institute; IAPT = increased access to psychological therapies.

* Examples are not presented separately but can be found in the text on the respective page.

Source: OECD *Mental Health and Work* country reports (see list of references).

Implementation is lagging behind aspiration

9. Many of the policy examples are characterised by a considerable discrepancy between very ambitious intentions and rather modest implementation. For instance, national mental health plans or strategies, such as in Australia and Norway, tend to have high ambitions to set the agenda for better integration of mental health and employment services but lack a clear definition of what each stakeholder would have to do in order to achieve the objectives. Legislation can suffer from a similar inconsistency. Belgium has detailed legislation on well-being at work with strong obligations for employers and their occupational physicians (OPs), for example, but this is badly implemented due to unfamiliarity among employers, high costs and low sanctions.

10. Weak policy execution is often the consequence of unclear roles for the involved stakeholders and professionals. It is largely up to the discretion of the professionals involved in what way co-ordination and integration is implemented. As a consequence, one and the same policy can be implemented in very different ways in different sites or locations, with different outcomes. The Increasing Access to Psychological Therapy (IAPT) model in the United Kingdom, which aims to provide jointly psychological therapy and employment advice, is one example. Integrated policies generally lack guidelines for multi-professional work to which all actors should conform. An exception is the Individual Placement and Support (IPS) model used in an increasing number of countries to bring people with more severe mental illness into the regular labour market. The strength of this model is the strict adherence to a clearly-defined set of characteristics (the so-called fidelity model), and the continuous monitoring of the implementation rules. Implementation of a programme can also be problematic because of the complexity coming with a more integrated delivery of policies and services.

11. Some new policies are first tested in the form of trials, but broader implementation does not always follow as expected based on the outcomes of the trials. Trials sometimes deliver promising outcomes just because the clients and the deliverers involved are highly motivated and considerable resources are invested to implement the new approach. If that investment is not matched in the full roll-out of policies, new policies will be less effective when offered throughout the country. One example here is the Dutch mental health guideline for occupational physicians (OPs) which delivered good outcomes in a randomised controlled trial but when it became available nation-wide, uptake proved to be poor even after OPs had been trained in using it.

12. Finally, the sustainability of employment outcomes tends to be neglected in programme development. For instance, public employment services typically aim to place a person into a job without providing on-the-job support. Also OPs, who are responsible for supporting people in their return to work after long-term sickness absence, tend to devote little to no attention to follow-up support. Yet, evaluations of IPS models have repeatedly shown that the initial success of placing people with a mental disorder in a job is not sustained in the long run. Programmes need to aim for improving longer-term outcomes and evaluate effectiveness in this.

13. Without rigorous implementation of integrated service delivery, policies will not improve outcomes. Key success factors for thorough implementation include strong leadership at the political and managerial level; awareness and understanding of the need for integrated services at all levels of an organisation and of the consequences of not delivering such services; and identification of mental health problems in all sectors (education, social, employment and health).

Rigorous evaluation is rare

14. New forms of service delivery often come with initial investments which will eventually pay off if the service is cost effective. Yet, much more empirical analysis and rigorous evaluation of integrated

services are needed. Many of the examples presented in Part 2 of this paper suggest that outcomes have improved, but little is known about the total costs and benefits of an intervention and the associated deadweight losses and substitution effects. For example, for the Swedish DELTA programme, which aims at a pooling of funding resources for rehabilitation, and the Belgian partnership programme between the mental health, employment and welfare sector, improved employment outcomes were found among the people receiving these services. However, the outcomes were not compared with a control group, which makes it difficult to assess the cost-benefit effect of the new programmes.

15. Ideally, an economic evaluation would be undertaken alongside a randomised controlled trial to assess the business case for a new programme or intervention. For example, both Lo Sasso et al. (2006) and Wang et al. (2006) showed that the costs of enhanced care for depressed workers were outweighed by benefits in terms of increased work productivity, reduced turnover and lower psychiatric hospitalisation over a period up to five years. Similar evaluation of other programmes could provide a strong incentive for institutions to collaborate.

16. Too little is also known about what works for whom, i.e. what type of integrated service is needed and effective for which target group – distinguishing for example those who have a job from those outside the labour market, or those with a common mental health problem from those with a more severe mental illness. Some types of integrated services – especially those arising in the health sector – have traditionally been provided to people with a severe mental illness only but could potentially be applied to people with common mental health problems as well. This group creates much larger economic costs than the group with severe disorders due to the sheer number. For example, the principle of "first place then train", well-accepted in IPS, could contribute to an earlier return to work among people with common mental health problems, who, in many countries, still do not return to work until fully able to function again. Similarly, Employee Assistance Programmes, which are primarily focused on support to employees with substance abuse disorders, are a good format for addressing any kind of personal problems that influence work performance. Such programme could be used more often to provide easy-access support for employees with common mental health problems.

17. Better data and stronger evaluation is evidently needed for policymakers to be able to decide which polices should be continued or rolled-out. However, better data and outcomes from ongoing monitoring also need to feed back to the professionals and practitioners involved to assure constant improvement in the way policies and services are delivered and implemented.

Adequate knowledge and incentives for the key actors

18. Delivering better integrated services implies involving a large number of stakeholders from different sectors and convincing them of a new service approach. This requires in the first place awareness among the key stakeholders of the need for such services, but it also requires considerable knowledge building about the bi-directional link between mental health and employment and the large impact and spill-over of policy from one field onto the other.

19. In this regard, it is particularly important to inform, involve and empower actors outside the mental health sphere, in particular teachers, employers, public employment service caseworkers and general practitioners (GPs). These professions are typically the first-line actors confronted with common mental illness. Mental health awareness training and other types of empowerment for these actors on how to communicate about mental health and work (or education) issues with their students, workers, clients or patients, is scarce. An exception is the mental health training provided to GPs in Denmark and Australia. This approach should be further extended to active training of teachers and supervisors who interact with people with mental health problems on a daily basis.

20. Awareness and mental health knowledge is only one side of the coin. To assure changes in the way services are delivered, strong and clear financial incentives are equally important. Many of the promising policy examples suffer from a lack of attention to incentives to provide better or more integrated services. For example, doctors are not rewarded for addressing work issues of their patients and, therefore, continue to focus on improved functioning only. Similarly, public employment services have no funds to address their clients' mental health issues and generally expect clients to be fit and healthy. Financial co-ordination between sectors is the simplest way to address the lack of integrated service provision, either through one sector receiving budget to purchase services from another sector, like the Rehabilitation Guarantee in Sweden, or by pooling resources of different institutions for services for shared clients as in the DELTA programme (also in Sweden).

21. The voluntary nature of service co-ordination and integration can also be detrimental to better outcomes. If sectors and services can choose not to cooperate, there is no guarantee for a sustained collaboration in the long-run nor is there effective follow-up of individuals who need multiple services. The voluntary nature of the inter-institutional co-operation under IIZ MAMAC in Switzerland was one of the reasons for the disappointing results of the programme. Other examples can be found in case management structures, such as the Dutch occupational health system or the Swiss private sickness insurers, where communicating and co-ordination with health care providers is particularly difficult as case co-ordinators often do not have the authority or leverage to impose instructions or recommendations on health care providers.

22. Voluntary use of services and the non-committal nature of service provision can also explain to a considerable degree the low take-up from which many of the integrated services suffer. It cannot be left to the clients whether they take up a service. This links back to the main policy implementation issue: the lack of binding rules and guidelines on when and how to offer services to whom.

Finding the best way to organise integrated services

23. Finally, a key issue is to identify the best and most effective way to organise and finance a more integrated delivery of mental health and work services. What type of co-ordination and integration works best? To answer that question it is important to keep in mind that integration is a means to reach a specific goal (e.g. to improve health, functioning, productivity and employment) and should not become a goal in itself.

24. Policy change can also be introduced gradually, with information-sharing and knowledge-building activities preparing the grounds for deeper service co-operation and integration. The guidelines for health care providers in Sweden and the Netherlands to improve knowledge about the interplay between mental health and work will help change behaviour in the sector but also facilitate co-operation with other sectors.

25. A related question is who should be taking the lead. Should integrated delivery be initiated in or by the mental health sector or the employment sector (or, for young people, the education sector)? The answer is not either-or; both sectors are needed and both sectors should take the lead where this is appropriate. The guiding principle should be the following: wherever someone enters the system – be it through the health system by seeing a general practitioner or through the employment system by visiting the PES – the provision of integrated supports and services must be assured.

26. Importantly, integrated services should be delivered as early as possible and as early as needed. Late intervention is the second big challenge for policies aiming to help people stay in or return to work. Integrated services in particular tend to be offered too late because they target a group with complex problems, which has often been out of the labour market for a very long period. Better outcomes will hinge on provision of integrated services at an earlier stage.

27. Different forms of linkages, co-ordination and full integration can and should exist alongside each other. High-level policy initiatives like the National Strategic Plan in Norway, for example, will not by itself change the landscape but provide strong backing and leadership for change at the delivery level. For issues which are relatively new, such as providing support to youths at risk, new entities that do not have to struggle with linking and harmonising existing services and their funding mechanisms seem to be the most effective way to go, as seen from the Youth Clinics in Sweden, the Student Guidance Centres in Flanders (Belgium) and Headspace in Australia.

28. Comparing the examples, their development, achievements and effectiveness, one observation can be made: cross-sector partnerships and service integration and the merging of institutions are time consuming and costly. More integrated provision of services in each and every sector seems a considerably easier and more realistic undertaking. Several of the within-sector full integration examples are particularly promising. The examples from the United Kingdom, Belgium, the United States and Australia, where employment services are embedded in the health sector, show the most positive employment outcomes. Although proper evaluations are sometimes lacking, results of these different examples point in the same direction and provide three important insights. First, integration of mental health and employment services is not only beneficial for severe mental disorders (e.g. the IPS model) but also for common mental disorders (e.g. UK's IAPT model). Second, the four countries differ significantly in the organisation of their health care, employment and social benefit sectors, but despite these contextual differences it has been possible to develop a model of integrated health and employment services in each context. Third, the provision of mental health care alone, or separately from employment support, is not enough to have a positive impact on employment outcomes.

29. In conclusion, integrated mental health and employment services can improve labour market outcomes for people with mental ill-health if implemented rigorously. However, some of the gains will be realised in other sectors than where investments have been made, and not every sector might see its costs reduced; certainly not in the short run. Therefore, setting the right incentives for the services and governments involved is paramount. In the end, integrated services will be cost-effective in the sense that they will achieve more for every unit of currency invested.

PART TWO

LEARNING FROM PROMISING POLICIES ACROSS OECD COUNTRIES

30. Several OECD countries have made a promising start towards connecting mental health services and employment services, and in connecting these services with the health, education and social policy sectors. The examples presented in this paper are taken from the OECD Mental Health and Work reports on Australia, Austria, Belgium, Denmark, the Netherlands, Norway, Sweden, Switzerland and the United Kingdom (see list of references). To structure the presentation of the country examples, a framework of different degrees and types of service integration is provided in the following section. This is meant to guide readers through the long list of examples. The structure is derived in a practical way based on the examples available. Several examples contain different policy elements and could therefore be grouped under different headings, depending on what element is given the main focus.

Defining "integrated services"

31. The literature on models of integrated services mostly stems from the health care sector and focuses on integrating different health services and sometimes social services (i.e. "integrated care") without looking at integrating employment services (Shaw, Rosen and Rumbold, 2011; Kodner, 2009). Nevertheless, this literature is helpful in defining integration and providing a framework for discussing integrated mental health and employment policies, systems and services.

32. Following Leutz' (1999) definition of integration, we define integrated mental health and employment services as a connection between the mental health care system and the employment support system to improve work-related outcomes, such as employment, return to work and work functioning. The degree or intensity to which policies realise a connection between mental health and employment services can vary. A helpful framework for classifying the degree of integration is along three levels (Shaw, Rosen and Rumbold, 2011; Kodner, 2009; Leutz, 1999):

- *Linkage*. This is the least-change approach in which systems or organisations work together on an ad-hoc basis. Parties are aware of the different needs of their clients and the other parties involved. The focus is on facilitating communication to ensure continuity of care. Responsibilities and financing are clearly divided between parties.
- *Co-ordination*. This is structured, inter-organisational action with a focus on co-ordinating services, managing transitions between settings and assigning primary responsibility for co-ordinating services. Co-ordination goes beyond linkage because of the purposefully developed and implemented policies to manage co-ordination of services. Responsibilities and funding are still separated.
- *Full integration*. Here, a "new entity" is formed that combines responsibilities, resources and financing in a single organisation or system to deliver and pay for the whole continuum of care. This entity could be completely new, result from a merging of two or more existing entities or develop within an existing entity.

33. What follows are innovative examples in a new policy field; examples with considerable potential if implemented rigorously. The examples of service integration described in this paper are rich and diverse but in many ways also still rather limited. None of the examples is singularly the one to be followed, but each example contains interesting elements of policy co-ordination or integration, which countries can learn from. In practice, many of these examples can and should be combined.

Linkages between sectors and services

34. Linkage is the first degree of integration in which systems or organisations search for ways to improve communication as a result of acknowledging shared responsibility for the same clients. The paper differentiates between high-level initiatives (i.e. declarations of the need of service integration), information sharing and knowledge building. All three linkage activities could potentially act as an instigator for realising more integrated services.

Whole-government initiatives

35. A first step to close the gap between mental health and employment services is through creating awareness of the importance of collaboration between these systems. Whole-government policy declarations can contribute to setting the agenda for better service integration. However, this requires strong political leadership at all government levels. Some countries have made significant steps in the move towards: a) what is sometimes referred to as a "health in all policies" approach – recognising that mental health inherently is a cross-sectional matter – or b) incorporating a focus on work in the mental health sector. This is mirrored in a number of government strategies and action plans:

> Australia
>
> In response to criticism from community stakeholders on the slow implementation of the mental health reform agenda, a Ten Year Roadmap for National Mental Health Reform was endorsed in 2012 by the Australian government. The Roadmap notes that mental health reform must be across sectors and service settings (e.g. employment services need to address mental health issues). The Fourth National Mental Health Plan (2009-2014) and the Roadmap aim to: i) prevent and detect mental illness early; ii) promote mental health awareness to reduce stigma and discrimination; iii) improve access to mental health services and treatment rates; and iv) improve social and economic participation, including through employment services.
>
> Norway
>
> To build a bridge between employment services (NAV) and mental health care, the Ministry of Health and the Ministry of Labour have elaborated a national strategic plan for work and mental health for 2007-2012. The plan outlined policy directions and defined measures to be taken in the areas of co-operation, user involvement, employment and health services, information and professional competences, and research and development. Measures contained, among others, the establishment of follow-up guides in the NAV offices to provide on-going support, the implementation of a supported-education scheme and the development of a course pack on mental health for the workplace.
>
> United Kingdom
>
> The Outcomes Framework of the National Health Service (NHS) for England for 2012/13, which the government will use to hold NHS England to account for, includes two sub-indicators on employment of people with long-term health conditions and those with mental illness. The Public Health Outcomes Framework includes these same two indicators and another one on sickness absence rates.

36. These overarching initiatives vary considerably in the extent to which mental health is linked with employment, and the degree to which employment is seen as relevant and an explicit target for mental health policy. Moreover, for these strategies to bear fruit they would need specific targets and on-going monitoring of the fulfilment of these targets – but this is often lacking.

37. In Norway, monitoring of the outcomes of the strategic plan is minimal and a rigorous evaluation is not yet available. However, the Norwegian government has launched a follow-up plan already (National Follow-up Plan on Work and Mental Health 2013-2016), which focuses on the co-operation between education, employment services and mental health services, e.g. by strengthening: i) county co-ordinators who

systematically co-ordinate the services for people with mental health problems in a region and are responsible for knowledge transfer between the labour and welfare system and the health services; the follow-up guides, who are specialised in mental health problems and provide integrated long-term support for the clients and have a link to the education system; and ii) the employer support centres which give courses and counselling to employers to increase their ability to prevent, identify and handle employees with a mental health problem. In Australia, along with the Ten Year Roadmap, a National Mental Health Commission was established. Independent of government, the Commission aims to work across all jurisdictions and sectors to help transform systems and promote change, so that all Australians achieve the best possible mental health and wellbeing. The Commission reports on progress in regard to the aims of the Roadmap through National Report Cards – showing limited success so far. For the United Kingdom, the power of the two sub-indicators on employment will hinge on the extent to which the responsible health authorities will be evaluated against and possibly reimbursed for the achievement of these targets, but no information is available on this up until now.

Information sharing

38. A key step in moving from a sectoral to an integrated approach is to make the relevant actions of each sector transparent to other sectors and to share information systematically. Often, sectors deal with the same clients in a separate way, while they could benefit from each other's expertise to obtain better outcomes:

Netherlands

To improve care for people with mental health problems on public sickness and disability benefits, the Dutch Employee Insurance agency (UWV; a governmental organisation responsible for public employment support) and the Dutch Association of Mental Health and Addiction Care (GGZ Nederland) signed a covenant in 2012 aimed at improving co-operation. Both parties will invest in knowledge exchange, with UWV providing information about the function of work in the recovery process and GGZ Nederland providing information about mental disorders. The goal is to jointly guide clients with a focus on optimal reintegration.

Switzerland

In several regions of Switzerland, the associations of employers and physicians have elaborated the so-called "expanded medical sickness certificate" to i) give employers more work-related information about employees on sick leave; ii) reinforce an earlier (often part-time) return-to-work; and iii) improve the co-operation between employers and physicians.

The employer can ask the treating physician for an expanded medical certificate providing more information than a normal certificate, which only indicates the cause (accident, illness or pregnancy), grade and duration of the work incapacity. The employer has to send a description of the workplace and the work tasks to the physician. This description must be signed by the employee, who, thereby, gives consent to the expanded medical certificate. The employer can also indicate whether contact with the physician is wanted. Based on the workplace description, the physician describes what work tasks can or cannot be conducted by the employee while he is on (part-time) sick leave. The employer had to bear the costs for the expanded medical sickness certificate.

Austria

In order to provide more return-to-work support for people on long-term sick leave, the Austrian government – together with the social partners and social insurances – initiated the "fit2work" programme. This is a new low-threshold service providing information, counselling and support for sick-listed employees and unemployed persons as well as for enterprises. The programme is aimed at avoiding job loss or long-term unemployment. The health insurance contacts the sick-listed employee after around 40 days of sickness absence, offering general information (e.g. about treatment possibilities) and – if necessary – counselling and support. Access to psychotherapists is facilitated in case of a mental health problem.

39. The three examples have shown differing results with regard to bringing the mental health and employment sector closer together. Following the covenant in the Netherlands, a work plan was developed for the support of people with severe mental disorders (i.e. Individual Placement and Support programmes in mental health care with employment support provided by UWV). However, for people with minor mental disorders little has happened yet; a research group is investigating what kind of collaboration between UWV and GGZ Nederland is desirable, including an inventory of already existing collaborative activities between the two parties (GGZ Nederland/UWV, 2012). In Switzerland, anecdotal evidence suggests that the joint work of employer and physician associations to develop the extended certification has been effective in creating improved dialogue and mutual trust between employers and physicians. Moreover, agreements between employers and physicians are being developed as a base for the new certificate (Ebnöter, 2014). Thus, the expanded sickness certificate is having a positive effect on the creation of partnerships between the health and employment sector. However, the new certificate is not widespread yet. Finally, the Austrian fit2work service is showing discouraging results so far with only 10% of all sick persons eligible for the service responding, no systematic link with the health system and hardly being able to reach employers.

40. Overall, to improve information sharing between mental health and employment services, more and better data collection will be needed. Information sharing has become easier in recent times due to better data collection systems. Electronic health records are increasingly becoming standard in OECD countries. Linking health data with other data is still rare but becoming possible; the Danish e-Health Clinical Database, for example, was expanded recently to include employment information. Initially, only current employment and benefit status is being recorded, but in the future, tracking health and employment histories in parallel could be an option. This could contribute to developing knowledge about the interplay between health and work, addressing health and employment issues simultaneously and reducing barriers for contact between health and employment specialists.

41. Sharing patient information generated by the health sector with other sectors is delicate as it can raise significant confidentiality and data protection issues. This issue can be solved in many cases in practice by seeking the patient's consent. However, a more thorough solution to the confidentiality issue may be needed. A patient's consent will be dependent on the relationship with those receiving the information. Especially in case of strong stigma and fear of job loss, patients might be reluctant to agree to their information being shared with their employer or with employment specialists.

Knowledge building

Health sector

42. It is central to train and guide health care providers about the impact of mental ill-health on employment and the relevance of employment for good mental health. Such information is particularly important for GPs who are often responsible for sickness certification, the gateway into long-term disability benefits and usually the first, or in some cases the only, doctor to see a patient with a (common) mental disorder. Some countries have developed guidelines for health care providers to improve knowledge about the interplay between mental health and work:

> Sweden
>
> In 2005, the Swedish 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 illness-specific recommendations including guidelines on anxiety, depression and schizophrenic conditions. The recommendations cover different aspects of relevance for judging the individual case, such as expected prognosis, effective treatment and length of sickness absence. The recommendations in the guidelines are based on a combination of

available scientific evidence and consensus among different specialists. 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.

Netherlands

To manage work-related problems of people with mental disorders and to better coordinate treatment provided by the GP, OP and psychologist, treatment guidelines for these professionals have been developed in the Netherlands.

The guidelines provide information on how to support return-to-work of people with common mental disorders following a three-phase process: i) provide a rationale for why sickness absence occurred, educate the worker about future prospects and structure daily life; ii) address problems that caused sickness absence and stimulate the worker to generate solutions to return to work; and iii) start gradual return-to-work and implement the solutions. Additional information is provided on the roles of the different health care providers and when contact or referral is deemed necessary.

In addition, a multidisciplinary guideline is available on the co-operation between GPs, OPs and psychologists in treating work-related distress and burnout.

43. In both countries, the guidelines have improved clients' work outcomes. The Dutch OP guideline has been evaluated in a cluster-randomised control trial and proved to be effective in improving return to work; on average, people treated according to the guideline returned to work 17 days earlier compared with people receiving treatment by the OP without the guideline (van der Klink et al., 2003). Even though better guideline adherence was related to a reduction of sickness absence (Rebergen et al. 2010; Nieuwenhuijsen et al., 2003), evaluations showed limited compliance with the guideline by Dutch OPs (about 50%) and limited use of the guidelines by Dutch psychologists (58%) (Oomens, Huijs and Blonk, 2009). For Sweden, evidence suggests that sickness absence guidelines for the most frequent illnesses have contributed to reduced incidence and shorter spells of sickness absence and a much narrower distribution of diagnoses. Also, the Swedish guidelines for GPs had a significant impact on GPs behaviour and attitudes. In a recent national survey of all GPs, around 76% of the GPs reported the use of the sickness guidelines. Nearly two-thirds of the GPs reported that the guidelines had facilitated their contacts with patients and one-third report improved communication with social insurance officers, other healthcare staff and employers (Skaner et al., 2011).

44. Other initiatives for increasing health care providers' knowledge of the interplay between mental health and work have focused on active training. Denmark has been quite successful in educating GPs on this score: most of them have taken e-training on stress, anxiety and depression, and the role of the GP in job retention. GPs in Denmark are also important providers of talking therapy; 80% of them provide psychotherapy sessions to patients with mental illness, and they are reimbursed for seven sessions per patient. Similarly, Australia has provided mental health skills training to two-thirds of all GPs with a focus on the assessment, planning and review cycle of common mental health conditions (those who took the training get higher reimbursement for providing therapies). In Austria and the United Kingdom, there is a discussion at the moment about extending initial training for GPs to include mental health, rehabilitation and work aspects.

Employment sector

45. It is equally important to create mental health knowledge in the employment sector, for instance, through training and guiding labour inspectors to assess work-related psychosocial demands in the workplace:

Denmark

Inspectors of the Work Environment Authority (WEA) have been trained in the use of guidance tools and the assessment and evaluation of health and safety risks in the psychosocial work environment

(PWE). 24 sector and job-specific guidance tools were developed. Each guidance tool describes the prevalence of risk factors and the resources of a company to prevent problems. The tool also describes possible organisational consequences of an imbalance between risks and resources, such as loss of commitment, high turnover rates or long-term sickness absence rates. In addition, PWE inspection has been facilitated through method descriptions and instructions, templates for preparing improvement notices, and best-practice sharing. In each of the four regional WEA inspection centres, a task force has been established consisting of 6-8 highly skilled PWE inspectors who assist other inspectors.

46. A full impact assessment of the Danish WEA strategy and the guidance tools has not yet been carried out. Preliminary results from focus group interviews with inspectors suggest that the guidance tools are used widely before, during and after an inspection and are considered very useful by employers. The number of improvement notices in relation to PWE problems has increased but still comprises only 5% of all notices issued by the WEA in relation to health and safety aspects (Senior Labour Inspectors Committee, 2008).

47. Of particular importance is educating employers about the interplay between health and work. Employers are not always aware of the impact mental health problems can have on an employee's work functioning (irrespective of the underlying cause of the problem), and the responsibility they have in supporting their employees at work or in return to work after a period of sickness absence. Without such knowledge, work and workplace adjustments are unlikely to be optimal (whereas information on the diagnosis, for example, is not necessarily of any importance). Education employers to deal with work-related mental health problems might also stimulate prevention:

Norway

The Norwegian Labour and Welfare Administration (NAV) implemented employer support centres (or, inclusive workplace centres) in each of its offices. These centres organise not only health promotion and sick-leave prevention campaigns, but also education courses and information sessions on mental health problems at the workplace for employers. More recently, projects have started with so-called advisors for work and mental health issues. These advisors, who are now available in several Norwegian counties, can be contacted directly by employers in concrete problem situations (e.g. to give advice about possible adaptations at the workplace).

48. Comparable employer counselling was part of a planned disability reform in Switzerland two years ago. The reform was refused by the parliament but is under discussion again. The reform foresees the provision of direct counselling at an early stage – i.e. before sickness absence occurs – by the local disability insurance office for employers if an employee is experiencing concrete (mental) health-related work problems. The aim is to close a critical treatment gap due to: i) under-treatment of mental health-related work problems because the majority does not lead to sickness absence, and (ii) reluctance among employers to seek external support or unawareness that problem behaviour is related to a mental health problem (Baer et al., 2011).

49. Better knowledge about mental health and how to address labour market barriers resulting from mental health problems is particularly important for the public employment service. In most countries the majority of the long-term unemployed struggle with mental health problems. This issue is slowly arising as a key policy issue in several OECD countries, but systematic identification of mental health problems among the unemployed and systematic information for caseworkers about the best way to deal with such problems remains scarce. Some countries collect information about diagnosed mental illness systematically in their intake tools, like for instance the Australian Jobseekers Classification Instrument. Other countries, like Austria, Belgium or the United Kingdom, provide some training about mental health to their caseworkers. Yet other countries, like Denmark or Sweden, have own psychologists in their teams who support caseworkers with assistance and advice.

Co-ordination of services

50. Co-ordination is the second degree of integration and goes beyond linkage as concrete efforts are undertaken to manage different policies and services coherently. Whereas linkage creates awareness of inter-relatedness of services, co-ordination goes one step further and adjusts different services to each other. The paper distinguishes three types of co-ordination: financial co-ordination, case co-ordination and partnership.

Financial co-ordination

51. Financial co-ordination allows institutions, providing different services, to make financial agreements with each other to ensure that their clients receive the support they need. Financial co-ordination assures that the responsible authority keeps financial responsibility even if a client has service needs that go beyond that authority's expertise. For example, one institution or sector could buy services from another, recognising that the other sector is better placed to provide this service efficiently:

> Sweden
>
> In 2008, the Swedish Ministry of Health and Social Affairs introduced a Rehabilitation Guarantee for people on sickness absence or at risk of longer-term absence as a result of long-standing psychological problems such as anxiety, depression or stress. Through this scheme, county councils (responsible for health care) can receive direct payment from the Social Insurance Agency (responsible for sickness and disability benefits) to buy treatment from the health sector for a client. The guarantee offers rehabilitation measures in the form of cognitive behavioural therapy (CBT) and interpersonal psychotherapy for a relatively short period (typically between 8-20 sessions).
>
> Austria
>
> Introduced as a pilot project in 2009 and recently rolled out nationally, the Health Road (Gesundheitsstraße) enables and mandates the Public Employment Service (PES; responsible for supporting unemployed people) and the Social Security Institute (SSI; responsible for supporting disabled people) to purchase each other's services to better support their clients. The PES pays the SSI for a work capacity assessment when unsure whether a client has the ability to move into employment. Similarly, the SSI pays the PES to provide vocational rehabilitation services for their clients who were assessed as having rehabilitation potential.

52. In Sweden, the results of the Rehabilitation Guarantee, i.e. the purchase of mental health treatment by the county councils for their clients, were mixed. Evaluation studies based on randomised controlled trials showed that for workers who were still at work, treatment reduced the risk of sickness absence compared to not receiving it. For people without a job, no positive effect on sickness absence was found, even though there were improvements in self-reported health (Karolinska Institutet, 2011). Thus, here, cross-funding was at least partially successful in realising better outcomes for the clients. For Austria, positive outcomes of the Health Road include the acceleration of the work capacity assessment process. In the past, people with potential inability to work could fall between the PES and SSI with both shifting responsibility towards each other. Now, the PES remains responsible to arrange the work capacity assessment through the SSI, which prevents dual and contradictory assessments, and the medical report has to be prepared within three weeks. During the evaluation period until late-2011, more than 5 000 assessments were completed of which 85% within one month (Hausegger, Reidl and Scharinger, 2012). The Health Road is hoped to result in more transparency for the client and the authorities, considerable savings and eventually earlier rehabilitation and better reintegration chances.

53. Another form of financial co-ordination is one whereby different actors pool resources with the aim to provide services more effectively and efficiently and to reduce long-run costs for everyone:

> Sweden:
>
> DELTA is a local association for financial co-ordination between the national employment service, the regional health authority, the municipal social service and the national social insurance administration. The DELTA association is financed by funds made available by these four participating institutions for support to benefit recipients with rehabilitation needs. The funds are pooled into a joint budget, which is allocated to different rehabilitation services provided by the association.
>
> Most of the activities under DELTA operate with the objective of early and co-ordinated rehabilitation and can be categorised under three main areas: 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. Multidisciplinary teams, consisting of professionals from the different sectors and institutions involved, carry out these activities; for example, physicians, nurses, physiotherapists, psychologists, economists, lawyers and social workers.

54. According to several evaluations, the DELTA programme has led to improvements in finding employment. Around eight out of ten formerly unemployed were able to maintain gainful employment, and two out of three formerly sick were no longer sick-listed (Wollberg, 2006). Users perceive the services as well integrated and adapted to their needs (Ahgren et al., 2009). However, little is known on actual co-operation between the different services.

Case co-ordination

55. Case co-ordination is a model in which one person, a case manager, co-ordinates the services offered by different institutions. Services are still delivered by and under the remit of each institution but clients are allocated to the best-suited service by the case manager. This approach prevents clients from being pushed around between institutions and has two additional advantages: first, one authority through the case manager is overlooking the entire process until (ideally) a client is brought into a job; secondly, the client does not have to present and re-discuss his/her situation over and over again.

Employment sector

56. Occupational physicians are a typical form of case co-ordination in the employment sector:

> Netherlands
>
> In the Netherlands, occupational physicians (OPs) are responsible for co-ordinating sickness management. They are well installed in each company, as the law obliges employers to consult an OP in sickness management. OPs do not provide treatment themselves, but they provide return-to-work support and are as such the link between the employment sector and the health sector. When an employee becomes sick, an important role of the OP is to make a problem analysis and advise on a reintegration action plan within six weeks of sickness absence. Additionally, for workers with mental health problems, OPs need to contact the employee's GP to co-ordinate the reintegration activities with the GP's treatment plan and refer employees to the psychologist when necessary (if not already done by the GP). OPs should keep communicating with the GP and psychologist throughout the reintegration process to monitor progression. Employees need to provide their consent for communication between the OP and the GP and the psychologist.

57. Communication and co-ordination with the health care sector turns out to be particularly difficult. Guidelines describing the roles of different professionals and the necessary collaborative actions already exist for several years (see also section on linkage above). Yet, research has shown that only few OPs communicate with the GP; in a study evaluating OP treatment, for only 18 out of 240 sick employees (i.e. 8%) the GP was contacted by the OP (Rebergen et al., 2010). OPs often do refer employees to the psychologist or other specialised mental health care (90% was referred), but other studies have found that further communication after referral is minimal (LVE, NHG and NVAB, 2011).

58. In Switzerland, co-operation with an OP is not mandatory for employers. Yet, employers offering generous sickness benefits (through collective agreements, about 25% of the employees in Switzerland receive 80% of their wage for two years in case of illness) tend to have sickness management programmes similar to those in the Netherlands. Financial incentives can be a strong driver for voluntary investment in case management between the employment and health sector.

Education sector

59. Case co-ordination has also been organised to improve educational attainment and labour market outcomes for youth who are not in education, employment or training (NEET) or those with a high risk to drop out of education. These youth often struggle with multiple problems, such as social, behavioural and mental health problems, resulting in the involvement of various support systems.

> Austria
>
> The Youth Coaching programme is developed to help young people stay in the education system as long as possible and to reintegrate the NEET group into education and training. The three target groups are youth in their ninth school year (last year of mandatory schooling) typically age 15-16; NEETs under age 19; and young people with a disability or special educational needs under age 25. Youth Coaching is a graded three-step process, following early detection by teachers. Step one is a 3-hour initial consultation (educational counselling) leading to a target agreement. Step two is 8-hour counselling for students requiring more than the initial agreement including, where necessary, external experts such as social workers. Step three is 30-hour individualised case management for youths with multiple problems, with clear steps towards implementation of the target agreement and concluding with a clearing report. The youth coach will connect youths with, for instance, debt counselling or psychological services, and organise psychological therapy if necessary. An important element of the programme is the involvement of both parents and teachers and a strong focus on the student's resources.
>
> Australia
>
> Youth Connections provides a safety net for young people who have disengaged from education, or are at risk of disengaging, through the provision of individually-tailored case management and support to help them re-connect with education or training and build resilience, skills and attributes that promote positive life choices and wellbeing.
>
> The programme has three components: individual support services; outreach and re-engagement activities to find disengaged young people; and activities targeted at and promoting the capacity of education providers in a region. Individual support services are provided through case management and are flexible (for an extended period of time), holistic and have strong links to other service providers. The most common barriers addressed are low self-esteem, low literacy and numeracy, and behavioural problems.

60. Both programmes have resulted in re-engaging youth in education or employment. In Austria, of those participating in the Youth Coaching programme, so far only 7% have dropped out whereas of the

remainder, 85% have achieved an outcome in line with the target agreement. In total, 30% ended up in step-3 case management (Steiner et al., 2013). However, the programme has initially only been applied to youth in the ninth school year as this group is easily reached through their class teachers. For the other target groups (i.e. the NEET and disabled youth), better methods will be needed to reach out successfully, including close collaboration with other actors (e.g. youth work). In Australia, the Youth Connections service is delivered in 113 service regions by 67 organisations. Between January 2010 and April 2013, it provided support services to more than 63 800 young people; of those receiving support, about 24 000 commenced or re-engaged in education or strengthened their education engagement, another about 24 000 improved educational performance or attendance and 2 500 engaged in employment. A survey among service providers suggests that Youth Connections is also effective in establishing a lasting re-connection: six months after completing the programme, 78% were engaged in education, training or employment. A significant proportion experienced improved psychological outcomes (Dandolopartners, 2012).

Partnerships

61. Partnerships are probably best characterised as a formal co-operation between different sectors for certain clients, without merging services entirely. The subtle difference between case co-ordination and partnerships is that in the latter, all service providers sit together around the table regularly to discuss the multiple service need of their shared clients (while with case co-ordination, the case manager cannot influence the services offered by other institutions). Hence, partnerships are a more intense and more binding form of case co-ordination.

Belgium

In 2009, the Flemish Public Employment Service (VDAB) developed a programme in co-operation with the mental health and welfare sectors for jobseekers and disability and social welfare beneficiaries with severe medical, psychological or psychiatric problems. VDAB contracts on a yearly basis a specialised non-profit centre (GTB) to provide intensive activation programmes combining care and employment support. All services are financed by the Flemish Government and free of charge for clients.

The activation team consists of three players: i) the job coach; ii) the health coach; and iii) the empowerment coach. The three coaches are selected through a tender process and are paid a fixed amount per month. The three coaches discuss together the needs of the jobseekers and determine jointly the services that are needed to activate them:

- The *job coach* – employed by GTB – sets up an individual action plan together with the job seeker and brings the person in contact with the health coach and the empowerment coach who are responsible for identifying the right services in the health sector and welfare sector respectively. During the entire process, the job coach makes sure that the activation guidance has a focus on work.

- The *health coach* – typically a psychologist working in a psychiatric hospital or centre for mental health – focuses on the medical, mental, psychological or psychiatric problems and provides rehabilitation and training in, for instance, self-confidence, handling stress, assertiveness, getting the self-image right (dealing with under/overestimation), etc. Individual or group therapies are provided in-house or by partner providers.

- The *empowerment coach* of the welfare sector – typically from a non-profit organisation with experience in sheltered employment or employment care – focuses on the psycho-economical, psychosocial or social impediments and deals with issues such as mobility, personal budget, housing, leisure activities, etc. Also the empowerment coach works either on an individual or group basis.

62. The Belgian example presents a programme with strong partnership between the mental health, employment and welfare sectors through the formation of a team delivering services in close co-operation, but it remains restricted to people with severe mental disorders only. So far, limited information on results is available. Over the period 2007-12, 11% of the participants in the activation guidance programme effectively found a job in the regular labour market and no longer receive unemployment benefits. Another 5.5% and 2.8% moved into sheltered employment and labour care respectively (keeping in mind that only the most severe cases are treated in this special programme). The co-operation with a psychologist, focus on case management and multidisciplinary team meetings were evaluated as major strengths of the programme.

Denmark

To prevent that young adults (<40 years) with mental health problems and little work experience move onto disability benefits, a new rehabilitation model (also referred to a resource clarification programme) has been developed. This model invites (and pays) the health sector, the relevant labour market institutions, social services and the education sector to collaborate in a multidisciplinary rehabilitation team in the municipal job centres. The teams discuss the needs of a client, make recommendations and co-ordinates actions.

63. A main objective of this new approach in Denmark is to overcome problems with the organisation of different schemes and the co-ordination at the municipal and regional levels but also within the municipality. The failure of co-ordination often implies that people drop out from rehabilitation and, thus, from the labour market. The new model aims to ensure treatment where necessary, with work seen as *part* of the solution; it is neither focused on assessing the degree of illness (the health sector view) nor the degree of work capacity (the job centre view) but attempts to integrate these approaches.

64. The new approach is promising, but it is too early to tell how well it will work in practice and what its outcomes will be. Savings are estimated to be in the order of EUR 250 million annually in 2020 (470 million in the long run), under the assumption that a significant share of those who would otherwise move onto disability benefit will instead work in the open labour market (The Danish Government, 2013). A potential problem is that each institution involved continues to take decisions within its own remits, though on the basis of an agreed action plan.

Switzerland

IIZ MAMAC aims at improving the inter-institutional co-operation (IIZ) between cantonal and local authorities through/ i) a joint assessment of a person's work capacity that is binding for all institutions involved; ii) reintegration measures jointly agreed by all IIZ partners; and iii) making one institution responsible for managing a particular case throughout the entire process. The organisational form of the IIZ process differs substantially across cantons and communities, including structural as well as case-based forms of co-operation and also both formalised and more informal ways of co-operating. IIZ MAMAC clients need to fulfil two criteria: i) suffer from health problems and face social difficulties but have identified reintegration potential; and ii) be clients of at least three institutions (typically cantonal disability insurance, cantonal unemployment insurance and municipal social assistance).

65. Findings from the Swiss IIZ MAMAC programme were disappointing because the focus of all institutions involved continued to be on their own cost-containment rather than service efficiency and effectiveness for society as a whole. The project was well received by clients and adopted in most cantons but has neither improved labour market outcomes nor reduced costs. Insufficient financial incentives to engage and the voluntary nature of IIZ explain to a considerable degree why implementation was very

slow. Anecdotal evidence suggests that, despite all efforts to expand co-operation, it took maybe half a year on average for a client to be referred to an IIZ team; people then typically stayed 1-1.5 years in the co-operation during which their employability was gradually increased; and maybe between one-third and one-half of the clients eventually found a job, which however was often not sustained. IIZ reached too few people and came too late in most cases thereby reducing its impact significantly.

Provision of fully integrated services

66. The most comprehensive form of integration is the formation of one organisational entity in whatever form in which different types of services are provided alongside each other and all financed from the same funding source. Full integration can be established in different ways: across sectors, within a sector or by establishing a new entity which applies an integrated approach.

Cross-sector integration

67. Cross-sector integration implies merging existing services from different sectors. Examples of cross-sector integration of mental health and employment services are virtually inexistent, as this is probably the most difficult form of full integration to realise. Financing and compensation structures for mental health and employment services generally differ significantly, leading to substantial implementation and incentive issues. Not even mentioning the organisational challenges, as the case may be, of merging different institutions with their own cultures and habits.

Within-sector integration

68. An alternative to cross-sector integration is building capacity for integrated services within a sector. This option circumvents the complicated organisational and financial aspects of cross-sector mergers. It can thus be an efficient and effective way to deliver integrated services. However, it requires good understanding of the need for such services – or a clear business case – because a sector needs to decide to invest in services not usually seen as their core activity.

Health sector

69. A first example of within-sector integration is the introduction of mental health services in the primary health care sector:

> Netherlands
>
> Since 2008, the Dutch government funds the use of a mental health specialist within the GP practice to better enable GPs to support patients with mental health problems. The so-called POH-GGZ (Dutch abbreviation for Practice Support Professional for Mental Health) is hired by the GP, often from mental health care institutes, and supports the GP in diagnosing, treating and referring patients with mental health problems. More specifically, the POH-GGZ's responsibilities are: problem analysis/screening, developing and discussing the treatment plan, providing psycho-education, guiding/supporting self-management, providing interventions aimed at behavioural change, indicated prevention and relapse prevention. The POH-GGZ is not authorised to prescribe medication, but closely collaborates with the GP to ensure coherent treatment. The professional background of the POH-GGZ is most often a psychiatric nurse (63%), psychologist (10%), social worker (7%) or general nurse (6%).

70. The implementation of the POH-GGZ in Dutch primary care settings has been successful. Over the past years, the use of a POH-GGZ by GPs has increased from 11% in 2009 to 62% in 2013 (LHV, 2013). An evaluation of GPs' experiences showed that 90% assessed the co-operation with the POH-GGZ

as good or excellent. GPs valued the POH-GGZ because of easy communication, low threshold for patients and expertise on mental disorders, counselling and referral to specialised mental health care (Dozeman and van Straten, 2012). Patients also reported that they are satisfied with the way they were treated by the POH-GGZ and the quick, client-centred actions (ter Horst and Haverkamp (2012).

71. The Dutch example integrates two different parties within the health sector (i.e. primary care and mental health care), but could easily be duplicated to integrate employment services within the health sector and mental health sector. In an increasing number of countries, the mental health sector has recognised the key role of employment for mental health and started offering employment services:

United Kingdom

To provide integrated employment and health services, *Employment Advisers* (EAs) were introduced in the *Improving Access to Psychological Therapies* (IAPT) programme. IAPT services offer fast access to evidence-based psychological treatment for people with a common mental disorder. The EAs work alongside the IAPT therapists, providing practical advice and relevant intervention to help people remain in work or enter the workplace. Access to IAPT services is by self-referral or GP referral.

United States

The Individual Placement and Support (IPS) model is a "first place then train" approach offered in secondary mental health care settings to help people with severe mental illness to get back into employment. Employment specialists work alongside mental health care specialists in multidisciplinary teams. The key principles of the IPS model include: i) competitive employment; ii) eligibility based on individual choice – no exclusions; iii) individualised job search; iv) job search within four weeks; v) employment specialists and clinical teams work and are located together; vi) continuous in-work support; vii) employers are approached with the individual's needs in mind; and viii) support through the transition from benefits to work.

Australia

Orygen Youth Health is an interesting example of an employment service embedded in a clinical service. Orygen is a state-funded hospital-based youth mental health service, which experiments with employment counsellors who are directly employed by the health service.

Orygen focuses on three youth target groups: i) early or first psychoses, ii) mood disorders and iii) personality disorders. However, the aim is to seize and help young people early in their development of a mental health problem. Therefore, Orygen does not wait until people have been assigned a disability tag and has a strong focus on early prevention when the first signs of mental illness arise. Referrals come from schools, families and the community but rarely from GPs.

Returning to school, training or employment are common goals for young people attending the Psychosocial Recovery Programme at Orygen Youth Health. Young people can work on their job interview skills, update their resume, explore their skills and identify training that they might want to pursue. The Group Programme may be offered as a first step in vocational recovery by providing structure and routine and opportunities to participate in meaningful activities with others. Qualified teachers are available on site to support young people to stay at, or return to, school. Vocational group programmes such as catering and horticulture are offered through the Group Programme and co-facilitated by clinicians and teachers. Those ready to return to work have access to employment consultants from outside agencies and a consultant employed at Orygen. The Psychosocial Recovery Programme works in partnership with job agencies to support young people in their return to work.

72. All three country examples have shown to be successful in improving employment outcomes for people with mental health problems. In the United Kingdom, the employment advisors provided an added value to the IAPT services both in terms of facilitating a quicker return to work from sick leave and increasing the likelihood to remain in employment. Of those who were on sick leave when they started seeing the EA, 63% returned to work, 9% were still in employment but remained off sick, and the remaining 29% left employment. Of those who were working when they first saw an EA, 84% were still at work when they stopped seeing their EA (Hogarth et al., 2013). People with employment and health problems highly valued coordinated support from employment and health services.

73. The United Kingdom example has not been evaluated in RCTs but IPS and Orygen have and also show positive results in terms of employment outcomes. A multisite randomised controlled trial of IPS in six European countries showed that 55% of the individuals assigned to IPS worked for at least one day during the 18-month follow-up period compared with 28% of the individuals assigned to vocational services. Individuals assigned to vocational services were significantly more likely to drop out of the service (45%) and to be readmitted to hospital (31%) than people receiving IPS (13% and 20%, respectively) (Knapp et al., 2013). Overall, there is strong evidence that IPS, with its "first place then train" approach, produces better employment outcomes than alternative and more traditional vocational services, with "first train then place" approaches, at lower cost to the health and social care systems (Knapp et al., 2013; Drake and Bond, 2008). Similarly, Orygen's integrated service for youth has shown to be more effective than health intervention alone; RCTs find very good outcomes with 85% of the participating youth moving into education or employment compared to 29% in the control group, which received the usual employment service. Success factors of Orygen's employment counsellors include the low caseload of around 20 clients and the focus on prevention and early intervention (before clients are set towards inactivity).

Employment sector

74. Also the employment sector is starting to realise the need and advantage of offering mental health services in-house, but fewer initiatives of within-sector integration are found than in the health sector. By hiring mental health specialists, employment services can support their caseworkers by identifying mental illness, providing low-threshold therapies and referring clients quickly to the regular mental health service if needed:

> Denmark
>
> Several specialist private employment services operate very effectively with caseworkers who are all trained psychologists. An example of this is the return-to-work programme of the Psychiatry Fund (a non-profit organisation founded in 1996), which targets clients with a common mental disorder and a considerable labour market career who have been on sick leave for at least six months. Intervention is voluntary because motivation is deemed essential, and clients need to be ready to be helped; this will be determined in a preparatory meeting with the job centre (all referrals are coming from the job centre).
>
> The structured intervention combines education on the client's illness with tackling of workplace issues and short-term treatment through cognitive behavioural therapy. After initial clarification, the intervention would typically last 19 weeks: six weeks of (group) courses to help understand the illness and teach coping mechanisms, followed by 13 weeks of trial employment or apprenticeships of a few hours per week.

75. There is no evaluation available of the return-to-work programme of the Danish Psychiatry Fund. The intervention is essentially specialised casework with a particularly low caseload (of around 10) and run by people specialised in working with clients with a common mental disorder. Most of the counsellors are psychologists who talk to clients as life coaches, not therapists. The focus of the counsellor who has weekly one-to-one meetings with the client is on education and employment, not the client's personality; talking about returning to

work (often to a new workplace), psychological counselling and helping to access mental health treatment are key aspects during these meetings. Anecdotal evidence suggests that most clients end up in employment, but there is no longer-term follow-up. Immediate outcomes after the 19-weeks intervention are as follows: 34% are ready to move into education or employment; 42% start treatment with a psychologist or a psychiatrist; and 24% stop the course or move onto benefits. A random-assignment experiment could clarify the (cost)-effectiveness of this intervention.

76. In Belgium, the occupational health services differ from similar services in other countries as they are obliged to employ a mental health specialist in addition to the typical occupational physicians:

> Belgium
>
> Employers are obliged to appoint a psychosocial prevention advisor who assists the employer in the implementation of its psychosocial risks prevention policy. For companies with fewer than 50 employees, the psychosocial prevention advisor must be from an external prevention service to avoid conflict of interest. It is also strongly recommended (but not obligatory) to employers to appoint a confidential counsellor internally who is thoroughly familiar with the internal functioning of the company. These measures are part of the labour legislation on well-being at work, which states that employers are legally obliged to take all necessary preventative measures to protect the well-being of their employees. All employers are required to do a risk assessment to identify situations at the workplace that can generate psychosocial distress and establish prevention and action plans.

77. An evaluation of the Belgian legislation on well-being at work reveals that the practical implementation of the legislation remains deficient. Employers do not very often carry out the psychosocial risk analyses due to the high costs involved and the fear of a negative analysis. Also, many employers are not aware of their legal obligations and among employees there is a lack of awareness about the role and existence of the psychosocial prevention advisors and confidential counsellors. Finally, psychosocial prevention advisors have little to no time for the prevention of psychosocial risks, are not always trained to execute the wide range of possible risk assessments and prevention programmes (less than 5% of the prevention advisors are specialised in psychosocial aspects of work), and are seldom familiar with the workplace (Service public fédéral Emploi, Travail et Concertation sociale, 2011).

78. A potential future way to integrate health services in the employment sector is through web-applications to support the case manager. In the Netherlands, the Dutch Employee Insurance Agency (UWV, responsible for public employment support) is using a digitalised system to support its clients since 2013. To influence the behaviour and motivation of jobseekers UWV is further developing its system building on national and international experiences with e-services in the health sector in combination with strategies from behavioural science (such as communication science, marketing and social psychology). The possibility of offering internet-administered cognitive behavioural therapy for depression and anxiety through the digital system is currently being explored. If such digital therapy could be combined with face-to-face support, it would be a new and innovative way of delivering health services within the employment sector.

New entities using an integrated approach

79. A third way to fully integrate mental health and employment or education services (and possibly other services as well) is through the development of a new entity, specialised in integrated service delivery. It is also a way of circumventing difficult implementation and incentive issues. This approach seems most adequate for dealing with new problems for which no existing institution is taking responsibility. Otherwise, it is likely to be more expensive than within-sector integration because it involves setting-up a new service structure across the country.

Education sector

80. In the education sector, several country examples can be found of strong governmental initiatives to develop new entities offering integrated services for youth:

Sweden

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. Youth Clinics are an easy-accessible public service, free of charge, for youth up to 20 years of age. All youth clinics consist of at least one midwife, a general practitioner, a social worker and a psychologist. Individuals can make contact voluntarily, for instance by 'dropping in' the centres. Workers in youth clinics actively work to identify early signs of mental illness and deal with concerns related to social development of adolescents. Both individual counselling and short and long-term psychological treatment is available depending on the severity of the illness. Outreach activities are also an essential part of the clinics, which include study visits to school classes and informing schools about the available health services.

Belgium

In Flanders, student guidance centres (*Centra voor Leerlingenbegeleiding* – CLBs) assists schools in four core domains, *i.e.* learning strategies, educational career planning, psychosocial functioning and preventive health care. The centres work with multidisciplinary teams consisting of psychologists (typically the director of the centre), doctors, nurses, social workers and pedagogues. The CLB centres also perform regular medical check-ups and as such are structurally linked to both the Flemish Department for Education and the Flemish Department for Welfare, Public Health and Family. They operate based on the principle of universal surveillance for all students, on the one hand, and individualised, multidisciplinary and intensive guidance for students with greater needs, on the other hand. The work of the centres is mainly demand-driven and they intervene after a request from a student, parent or school, but they also play a key role in school dropout prevention, access to special and integrated education and regular medical check-ups. Besides giving information, support and guidance, the centres typically have a good overview of external services to which they can refer people if they cannot solve the issue themselves.

Australia

Headspace addresses the mismatch between the level of need and the amount of mental health service use among adolescents and young adults aged 12-25 years. There are 55 headspace centres located across Australia (scaling up to 100 centres by 2016) that bring together a range of professionals including psychologists, social workers, alcohol and drug workers, GPs, career counsellors, vocational workers and youth workers. Headspace centres are highly accessible, youth-friendly, integrated service hubs that provide evidence-based interventions and support to young people for their mental health, health and wellbeing needs. Each centre offers medical and vocational services, with the aim of providing holistic and integrated support.

The threshold for accessing headspace is very low (there are no requirements of any sort; most visits are through self-referral); hence, it has great potential for reaching young people with a non-diagnosed common mental disorder. Services are provided largely free of charge with high confidentiality. Headspace is increasingly working together with and referring to other services, such as government funded employment services (Job Services Australia and Disability Employment Services) or the Department for Social Services (which is responsible for eligibility assessments for income support payments and allowances, and referral to employment services). Headspace also has a school support program focussing on assisting secondary schools affected by suicide.

81. No evidence is available on the effectiveness of the programmes in improving mental health, school and employment outcomes. Nevertheless, an important strength is that the new entities are easily accessible and have a low threshold due to the fact that multiple youth-friendly services next to mental health support are provided, reducing stigma issues. This popularity could pose challenges regarding service capacity. For example, in Belgium, a CLB caseworker has a caseload of 400 students and there is an increasing demand for support from schools, parent and students. Additionally, long waiting lists for external services, such as mental health care, further increase the workload as CLB caseworkers continue to provide support until students have accessed specialised care.

Employment sector

82. Also in the employment sector, some interesting examples can be found:

United Kingdom

During 2014, a new *Health and Work Service* (HWS) will be put in place as a national service providing an in-depth assessment of how an employee's health is affecting the ability to work and advice on how people on sickness absence can be supported back to work. Assessments will be provided after an employee has been off work for around four weeks, supported by a case managed approach and followed by signposting to interventions. GPs have the prime responsibility to refer individuals to the new services. Once a referral is made, an occupational health advisor will assess the individual. After assessment, a return-to-work plan will be shared with the employee, the employer and the GP, outlining the obstacles preventing a return to work, interventions that would facilitate the return to work and a timetable for return to work.

United States

Employee Assistance Programs (EAPs) offer confidential, short-term counselling services for employees with personal problems that affect their work performance, whether or not those problems originate in the workplace. EAP services to individuals and their family include services related to mental health, drugs, alcohol and personal issues (such as divorce and parenting); wellness and health promotion; and work-related support (such as career counselling). EAPs also provide support to the employer, including education on handling mental health, stress and addictions in the workplace, and absence management.

EAPs are free of charge for the employee and their family members (pre-paid by the employer) and typically available 24 hours a day. EAPs are mandatory for federal agencies and the coverage in the private sector is around 65% for companies with more than 100 employees.

83. The establishment of the new HWS has considerable potential to tackle sickness absence by providing services at an early stage and brining occupational health care closer to employment issues. The HWS builds on experiences with an Occupational Health Advise Line and a dedicated Fit-to-Work Service trialled in different forms in the past few years. The success of the HWS remains to be seen. A few issues will have to be considered in implementing the new service successfully, including: effective co-operation between employers, GPs and advisors at the health services (there are no obligations and no enforcement tools or procedures); the tailoring of the new service for those with mental health problems; building capacity for the workforce of the HWS; assuring good take-up of the new services (take-up in the pilots was much lower than expected); and securing sustainable funding.

84. Generally, EAPs are offered to companies by external consultancy bureaus that have specialised in work-related mental health issues. However, in larger companies, EAP services could also be embedded within the company (i.e. such a structure would be exemplary of within-sector integration). In the United States, EAPs have shown to contribute to decreased absenteeism, greater employee retention and significantly reduced medical costs through early identification and treatment of mental health issues (Lam et al., 2012; Hargrave et al., 2008). Nevertheless, most EAPs are predominantly aimed at substance abuse disorders and remain under-utilised for other mental health problems. Also, programs have been criticised for the lack of impartiality in cases where an employee seeks assistance due to work-related issues.

REFERENCES

Ahgren, B., S.B. Axelsson and R. Axelsson (2009), "Evaluating intersectoral collaboration: A model for assessment by service users", *International Journal of Integrated Care*, Vol. 9, January-March.

Andersson et al. (2011), "Organizational approaches to collaboration in vocational rehabilitation – an international literature review", *International Journal of Integrated Care*, Vol. 11, pp. 1-10.

Baer, N., U. Frick and T. Fasel (2011), "'Schwierige' 'Mitarbeiter': Wahrnehmung und Bewältigung Psychisch bedingter Problemsituationen durch Vorgesetzte und Personalverantwortliche – eine Pilotstudie in Basel-Stadt und Basel-Landschaft" (Difficult employees: How supervisors recognise and cope with problem situations due to mental health reasons), FoP-IV Forschungsbericht, Bundesamt für Sozialversicherungen, Bern.

Dandolopartners (2012), "2nd Interim Evaluation of the National Partnership on Youth Attainment and Transitions", A report for the Department of Education, Employment and Workplace Relations.

Dozeman, E. and A. van Straten (2012), De praktijkondersteuner GGZ in Amsterdam: Op weg naar een sterke basis GGZ, [Mental health care counsellor supporting general practice in Amsterdam: Towards strong first-line mental health care], Vrije Universiteit, Amsterdam.

Drake, R. and G. Bond (2008), "Supported Employment: 1998-2008", Guest Editorial in the Special Issue on the 10th Anniversary on Supported Employment, *Psychiatric Rehabilitation Journal*, Vol. 31, No. 4, pp. 274-276.

Ebnöther, E. (2014), Das Arztzeugnis im Brennpunkt unterschiedlicher Interessen [The sickness certificate viewed from different perspectives], *Schweizerische Ärztezeitung*, 95:4, pp 108-111.

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

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.

Hargrave, G. et al. (2008), "EAP Treatment Impact on Presenteeism and Absenteeism: Implications for Return on Investment", *Journal of Workplace Behavioral Health*, Vol. 23(3), pp. 283-293.

Hausegger T., C. Reidl and C. Scharinger (2012), "Begleitende Evaluierung der Gesundheitsstraße", Endbericht, Prospect Research & Solution (Report for the Federal Ministry of Labour, Social Affairs and Consumer Protection), Wien.

Hogarth, T., C. Hasluck, L. Gambin, H. Behle, Y. Li and C. Lyonette (2013), "Evaluation of Employment Advisers in the Improving Access to Psychological Therapies programme", DWP Research Report 826, London.

Karolinska Institutet (2011), "En nationell utvärdering av rehabiliteringsgarantins effekter på sjukfrånvaro och hälsa, Slutrapport del I" [A national evaluation of rehabilitation warranty effects on absenteeism and health, Final Report, Part I], Stockholm.

Knapp, M., A. Patel, C. Curran et al. (2013), "Supported Employment: Cost-effectiveness Across six European Sites", *World Psychiatry*, Vol. 12, No. 1, pp. 60-68.

Kodner (2009), "All together now: A conceptual exploration of integrated care", *Healthcare Quarterly*, Vol. 13, pp. 6-15.

Lam, R. et al. (2012), "The Prevalence and Impact of Depression in Self-Referred Clients Attending an Employee Assistance Program", *Journal of Occupational and Environmental Medicine*, Vol. 54 (11), pp. 1395-99.

Leutz (1999), "Five laws for integrating medical and social services: Lessons from the United States and the United Kingdom", *The Milbank Quarterly*, Vol. 77, No. 1, pp. 77-110.

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

Lo Sasso, A., K. Rost and A. Beck (2006), "Modeling the impact of enhanced depression treatment on workplace functioning and costs: A cost-benefit approach", *Medical Care*, Vol. 44, No. 4, pp. 352-8.

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

Nieuwenhuijsen, K., et al. (2003), "Quality of rehabilitation among workers with adjustment disorders according to practice guidelines: a retrospective cohort study", *Occupational and Environmental Medicine*, Vol. 60, Suppl 1, pp. i21-5.

OECD (forthcoming/a), *Integrating Social Service Delivery for Vulnerable Groups*, OECD Publishing, Paris.

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

OECD (forthcoming/c), *Mental Health and Work: Austria*, OECD Publishing, Paris.

OECD (2014a), *Mental Health and Work: Switzerland*, OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264204973-en.

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

OECD (2014c), *Mental Health and Work: Netherlands*, OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264223301-en.

OECD (2013a), *Mental Health and Work: Belgium*, OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264187566-en.

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

OECD (2013c), *Mental Health and Work: Norway*, OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264178984-en.

OECD (2013d), *Mental Health and Work: Sweden*, OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264188730-en.

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

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

Rai, D. et al. (2010), "Common mental disorders, subthreshold symptoms and disability: Longitudinal study", *British Journal of Psychiatry*, Vol 197, pp. 411-12.

Rebergen D., et al. (2010), "Return to work and occupational physicians' management of common mental health problems – process evaluation of a randomized controlled trial", *Scandinavian Journal of Work, Environment and Health*, Vol. 36, No. 6, pp. 488-98.

Senior Labour Inspectors Committee (2008), "Report on the Evaluation of the Danish Working Environment Authority in 2008", Copenhagen.

Service public fédéral Emploi, Travail et Concertation sociale (2011), "Évaluation de la législation relative à la prévention de la charge psychosociale occasionnée par le travail, dont la violence et le harcèlement moral ou sexuel au travail", Brussels.

Shaw, Rosen and Rumbold (2011), "An overview of integrated care in the NHS: What is integrated care?", Nuffield Trust, London.

Skaner, Y., G.H. Nilsson, B. Arrelov, C. Lindholm, E. Hinas, A.L. Wilteus and K. Alexanderson (2011), "Use and Usefulness of Guidelines for Sickness Certification: Results from a National Survey of All General Practitioners in Sweden", *BMJ Open*, Vol. 2011:1, http://bmjopen.bmj.com/content/1/2/e000303.full.

Stansfeld, S.A., R. Fuhrer and J. Head (2011), "Impact of common mental disorders on sickness absence in an occupational cohort study", *Occupational and Environmental Medicine*, Vol. 68, No. 6, pp. 408-13.

Steiner M., G. Pessl, E. Wagner and J. Karaszek (2013), "Evaluierung Jugendcoaching- Endbericht" [Evaluation of youth coaching: Final report], Studie im Auftrag des Bundesministeriums für Arbeit, Soziales und Konsumentenschutz, Wien.

ter Horst, L. and S. Haverkamp (2012), Ervaringen van patiënten met de praktijkondersteuner huisartsenzorg GGZ [Experiences of patients with the mental health care counsellor in general practice], Zorgbelang Noord-Holland, Haarlem.

The Danish Government (2013), The National Reform Programme Denmark 2013, Copenhagen.

van der Klink et al. (2003), "Reducing long term sickness absence by an activating intervention in adjustment disorders: a cluster randomised controlled design", *Occupational and Environmental Medicine*, Vol. 60, pp. 429-37.

Wang, P., et al. (2006), "The costs and benefits of enhanced depression care to employers", *Archives of General Psychiatry*, Vol. 63, pp. 1345-53.

Wollberg, P. (2006), "Integrated service in rehabilitation – on co-ordination of organisation and financing", Host Country Report, *Peer Review and Assessment in Social Inclusion*, European Commission.

OECD SOCIAL, EMPLOYMENT AND MIGRATION WORKING PAPERS

Most recent releases are:

No. 160 *A NEW PROFILE OF MIGRANTS IN THE AFTERMATH OF THE RECENT ECONOMIC CRISIS, Arslan, C., et al. (2014)*

No. 159 *TRENDS IN TOP INCOMES AND THEIR TAXATION IN OECD COUNTRIES*, Michael Förster, Ana Llena-Nozal and Vahé Nafilyan (2014)

No. 158 *SKILLS AT WORK: HOW SKILLS AND THEIR USE MATTER IN THE LABOUR MARKET*, Glenda Quintini (2014)

No. 157 *CHANGES IN FAMILY POLICIES AND OUTCOMES: IS THERE CONVERGENCE?*, Willem Adema, Nabil Ali, and Oliver Thévenon

No. 156 *RETOUR À L'EMPLOI DES CHOMEURS SENIORS FRANÇAIS AYANT BENEFICIE D'UN ACCOMPAGNEMENT RENFORCE VERS L'EMPLOI EN 2009 ET 2010*, Gwenn Parent (2014)

No. 155 *MIGRATION AS AN ADJUSTMENT MECHANISM IN THE CRISIS? A COMPARISON OF EUROPE AND THE UNITED STATES*, Julia Jauer, Thomas Liebig, John P. Martin and Patrick Puhani (2014)

No. 154 *SAME BUT DIFFERENT: SCHOOL-TO-WORK TRANSITIONS IN EMERGING AND ADVANCED ECONOMIES*, Glenda Quintini and Sébastien Martin (2014)

No. 153 *A NEW MEASURE OF SKILLS MISMATCH*, Michele Pellizzari and Anne Fichen (2013)

No. 152 *CATASTROPHIC JOB DESTRUCTION*, Anabela Carneiro, Pedro Portugal and José Varejão (2013)

No. 151 *THE PERVERSE EFFECTS OF JOB-SECURITY PROVISIONS ON JOB SECURITY IN ITALY: RESULTS FROM A REGRESSION DISCONTINUITY DESIGN*, Alexander Hijzen, Leopoldo Mondauto, Stefano Scarpetta (2013)

No. 150 *REDISTRIBUTION POLICY IN EUROPE AND THE UNITED STATES: IS THE GREAT RECESSION A 'GAME CHANGER' FOR WORKING-AGE FAMILIES?* Herwig Immervoll, Linda Richardson (2013)

No. 149 *A BIRD'S EYE VIEW OF GENDER DIFFERENCES IN EDUCATION IN OECD COUNTRIES* Angelica Salvi Del Pero and Alexandra Bytchkova (2013)

No. 148 *TRENDS IN POVERTY AND INEQUALITY IN DECENTRALISING INDONESIA* Riyana Miranti, Yogi Vidyattama, Erick Hansnata, Rebecca Cassells and Alan Duncan (2013)

No. 147 *WOMEN ENTREPRENEURS IN THE OECD: KEY EVIDENCE AND POLICY CHALLENGES* Mario Piacentini (2013)

No. 146 *AN EVALUATION OF INTERNATIONAL SURVEYS OF CHILDREN*, Dominic Richardson and Nabil Ali (2014)

No. 145 *DRIVERS OF FEMALE LABOUR FORCE PARTICIPATION IN THE OECD*, Olivier Thévenon (2013)

No. 144 *THE ROLE OF SHORT-TIME WORKING SCHEMES DURING THE GLOBAL FINANCIAL CRISIS AND EARLY RECOVERY*, Alexander Hijzen, Sébastien Martin (2012)

No. 143 *TRENDS IN JOB SKILL DEMANDS IN OECD COUNTRIES*, Michael J. Handel (2012)

No. 142 *HELPING DISPLACED WORKERS BACK INTO JOBS AFTER A NATURAL DISASTER: RECENT EXPERIENCES IN OECD COUNTRIES*, Danielle Venn (2012)

No. 141 *LABOUR MARKET EFFECTS OF PARENTAL LEAVE POLICIES IN OECD COUNTRIES*, Olivier Thévenon & Anne Solaz (2012)

No. 140 *FATHERS' LEAVE, FATHERS' INVOLVEMENT AND CHILD DEVELOPMENT: ARE THEY RELATED? EVIDENCE FROM FOUR OECD COUNTRIES*, Maria C. Huerta, Willem Adema, Jennifer Baxter, Wen-Jui Han, Mette Lausten, RaeHyuck Lee and Jane Waldfogel (2012)

No. 139 *FLEXICURITY AND THE ECONOMIC CRISIS 2008-9 – EVIDENCE FROM DENMARK*, Tor Eriksson (2012)

No. 138 *EFFECTS OF REDUCING GENDER GAPS IN EDUCATION AND LABOUR FORCE PARTICIPATION ON ECONOMIC GROWTH IN THE OECD*, Olivier Thévenon, Nabil Ali, Willem Adema and Angelica Salvi del Pero (2012)

No. 137 *THE RESPONSE OF GERMAN ESTABLISHMENTS TO THE 2008-2009 ECONOMIC CRISIS*, Lutz Bellman, Hans-Dieter Gerner, Richard Upward (2012)

No. 136 *THE DYNAMICS OF SOCIAL ASSISTANCE RECEIPT IN* GERMANY Sebastian Königs

No. 135 *MONEY OR KINDERGARTEN? DISTRIBUTIVE EFFECTS OF CASH VERSUS IN-KIND FAMILY TRANSFERS FOR YOUNG CHILDREN*, Michael Förster and Gerlinde Verbist (2012)

No. 134 *THE ROLE OF INSTITUTIONS AND FIRM HETEROGENEITY FOR LABOUR MARKET ADJUSTMENTS: CROSS-COUNTRY FIRM-LEVEL EVIDENCE*, Peter N. Gal (VU University Amsterdam), Alexander Hijzen and Zoltan Wolf (2012)

No. 133 *CAPITAL'S GRABBING HAND? A CROSS-COUNTRY/CROSS-INDUSTRY ANALYSIS OF THE DECLINE OF THE LABOUR SHARE*, Andrea Bassanini and Thomas Manfredi (2012)

No. 132 *INCOME DISTRIBUTION AND POVERTY IN RUSSIA*, Irinia Denisova (2012)

No. 131 *ELIGIBILITY CRITERIA FOR UNEMPLOYMENT BENEFITS*, Danielle Venn (2012)

No. 130 *THE IMPACT OF PUBLICLY PROVIDED SERVICES ON THE DISTRIBUTION OF RESOURCES: REVIEW OF NEW RESULTS AND METHODS*, Gerlinde Verbist, Michael Förster and Maria Vaalavuo (2012)

No. 129 *AN OVERVIEW OF AUSTRALIA'S SYSSTEM OF INCOME AND EMPLOYMENT ASSISTANCE FOR THE UNEMPLOYED*, Peter Davidson, Peter Whiteford (2012)

No. 128 *THE INTEGRATION OF IMMIGRANTS AND THEIR CHILDREN INTO THE LABOUR MARKET IN SWITZERLAND*, Thomas Liebig, Sebastian Kohls and Karoline Krause (2012)

No. 127 *THE LABOUR MARKET INTEGRATION OF IMMIGRANTS AND THEIR CHILDREN IN AUSTRIA*, Karolin Krause and Thomas Liebig (2011)

No. 126 *ARE RECENT IMMIGRANTS DIFFERENT? A NEW PROFILE OF IMMIGRANTS IN THE OECD BASED ON DIOC 2005/06*, Sarah Widmaier and Jean-Christophe Dumont (2011)

No. 125 *EARNINGS VOLATILITY AND ITS CONSEQUENCES FOR HOUSEHOLDS*, Danielle Venn (2011)

No. 124 *CRISIS, RECESSION AND THE WELFARE STATE*, Willem Adema, Pauline Fron and Maxime Ladaique (2011)

No. 123 AGGREGATE EARNINGS AND MACROECONOMIC SHOCKS Andrea Bassanini (2011)

No. 122 *REDISTRIBUTION POLICY AND INEQUALITY REDUCTION IN OECD COUNTRIES: WHAT HAS CHANGED IN TWO DECADES?* Herwig Immervoll, Linda Richardson (2011)

No. 121 *OVER-QUALIFIED OR UNDER-SKILLED*, Glenda Quintini (2011)

No. 120 *RIGHT FOR THE JOB*, Glenda Quintini (2011)

No. 119 *THE LABOUR MARKET EFFECTS OF UNEMPLOYMENT COMPENSATION IN BRAZIL*, Alexander Hijzen (2011)

No. 118 *EARLY MATERNAL EMPLOYMENT AND CHILD DEVELOPMENT IN FIVE OECD COUNTRIES*, Maria del Carmen Huerta, Willem Adema, Jennifer Baxter, Miles Corak, Mette Deding, Matthew C. Gray, Wen-Jui Han, Jane Waldfogel (2011)

No. 117 *WHAT DRIVES INFLOWS INTO DISABILITY? EVIDENCE FROM THREE OECD COUNTRIES* Ana Llena-Nozal and Theodora Xenogiani (2011)

No. 116 *COOKING, CARING AND VOLUNTEERING: UNPAID WORK AROUND THE WORLD*, Veerle Miranda (2011)

No. 115 *THE ROLE OF SHORT-TIME WORK SCHEMES DURING THE 2008-09 RECESSION*, Alexander Hijzen and Danielle Venn (2010)

No. 114 *INTERNATIONAL MIGRANTS IN DEVELOPED, EMERGING AND DEVELOPING COUNTRIES: AN EXTENDED PROFILE,* Jean-Christophe Dumont, Gilles Spielvogel and Sarah Widmaier (2010)

No. 113 *ACTIVATION POLICIES IN JAPAN*, Nicola Duell, David Grubb, Shruti Singh and Peter Tergeist (2010)

No. 112 *ACTIVATION POLICIES IN SWITZERLAND*, Nicola Duell and Peter Tergeist with contributions from Ursula Bazant and Sylvie Cimper (2010)

No. 111 *ECONOMIC DETERMINANTS AND CONSEQUENCES OF CHILD MALTREATMENT* Lawrence M. Berger, Jane Waldfogel (forthcoming)

No. 110 *DISTRIBUTIONAL CONSEQUENCES OF LABOR DEMAND ADJUSTMENTS TO A DOWNTURN: A MODEL-BASED APPROACH WITH APPLICATION TO GERMANY 2008-09,* Herwig Immervoll, Olivier Bargain, Andreas Peichl, Sebastian Siegloch (2010)

No. 109 *DECOMPOSING NOTIONAL DEFINED-CONTRIBUTION PENSIONS: EXPERIENCE OF OECD COUNTRIES' REFORMS*, Edward Whitehouse (2010)

No. 108 *EARNINGS OF MEN AND WOMEN WORKING IN THE PRIVATE SECTOR: ENRICHED DATA FOR PENSIONS AND TAX-BENEFIT MODELING*, Anna Cristina D'Addio and Herwig Immervoll (2010)

No. 107 *INSTITUTIONAL DETERMINANTS OF WORKER FLOWS: A CROSS-COUNTRY/CROSS-INDUSTRY APPROACH*, Andrea Bassanini, Andrea Garnero, Pascal Marianna, Sebastien Martin (2010)

No. 106 *RISING YOUTH UNEMPLOYMENT DURING THE CRISIS: HOW TO PREVENT NEGATIVE LONG-TERM CONSEQUENCES ON A GENERATION?* Stefano Scarpetta, Anne Sonnet and Thomas Manfredi (2010)

No. 105 *TRENDS IN PENSION ELIGIBILITY AGES AND LIVE EXPECTANCY, 1950-2050* Rafal Chomik and Edward Whitehouse (2010)

No. 104 *ISRAELI CHILD POLICY AND OUTCOMES* John Gal, Mimi Ajzenstadt, Asher Ben-Arieh, Roni Holler and Nadine Zielinsky (2010)

No. 103 *REFORMING POLICIES ON FOREIGN WORKERS IN ISRAEL* Adriana Kemp (2010)

No. 102 *LABOUR MARKET AND SOCIO-ECONOMIC OUTCOMES OF THE ARAB-ISRAELI POPULATION* Jack Habib, Judith King, Asaf Ben Shoham, Abraham Wolde-Tsadick and Karen Lasky (2010)

A full list of Social, Employment and Migration Working Papers is available at *www.oecd.org/els/workingpapers*.

Other series of working papers available from the OECD include: *OECD Health Working Papers*.

RECENT RELATED OECD PUBLICATIONS:

MENTAL HEALTH AND WORK: NETHERLANDS, http://www.oecd.org/netherlands/mental-health-and-work-netherlands-9789264223301-en.htm

MATCHING ECONOMIC MIGRATION WITH LABOUR MARKET NEEDS, http://www.oecd.org/eu/matching-economic-migration-with-labour-market-needs.htm

EMPLOYMENT OUTLOOK 2014 , http://www.oecd.org/employment/oecdemploymentoutlook.htm

CONNECTING PEOPLE WITH JOBS UK, http://www.oecd.org/employment/emp/activelabourmarketpoliciesandactivationstrategies.htm

RECRUITING IMMIGRANT WORKERS NEW ZEALAND, http://www.oecd.org/migration/recruiting-immigrant-workers-nz-2014.htm

JOBS FOR IMMIGRANTS VOL. 4 ITALY, http://www.oecd.org/els/jobsforimmigrantsseries.htm

THE 2012 LABOUR MARKET REFORM IN SPAIN, http://www.oecd.org/employment/spain-labourmarketreform.htm

INVESTING IN YOUTH: BRAZIL (2014), www.oecd.org/employment/action-plan-youth.htm

AGEING AND EMPLOYMENT POLICIES: NETHERLANDS 2014, http://www.oecd.org/els/ageing-and-employment-policies-netherlands-2014-9789264208155-en.htm

OECD REVIEWS OF PENSION SYSTEMS: IRELAND, http://www.oecd.org/els/public-pensions/reforms-essential-to-make-irelands-pensionsystem-fairer.htm

AGEING AND EMPLOYMENT POLICIES: NETHLERLANDS 2014, www.oecd.org/els/employment/olderworkers

SOCIETY AT A GLANCE 2014, www.oecd.org/els/societyataglance.htm

MENTAL HEALTH AND WORK: UNITED KINGDOM (2014), www.oecd.org/els/emp/mentalhealthandwork-unitedkingdom.htm

VIEILLISSEMENT ET POLITIQUES DE L'EMPLOI : FRANCE 2014: MIEUX TRAVAILLER AVEC L'ÂGE, www.oecd.org/fr/emploi/emp/vieillissementetpolitiquesdelemploi.htm

MENTAL HEALTH AND WORK: SWITZERLAND (2014), www.oecd.org/els/emp/mentalhealthandwork-switzerland.htm

PENSIONS AT A GLANCE 2013, www.oecd.org/els/public-pensions/pensionsataglance.htm

HEALTH AT A GLANCE 2013: OECD INDICATORS, www.oecd.org/health/health-systems/health-at-a-glance.htm

OECD EMPLOYMENT OUTLOOK 2013, www.oecd.org/els/emp/oecdemploymentoutlook.htm

CLOSING THE GENDER GAP: ACT NOW, www.oecd.org/gender/closingthegap.htm

OECD PENSIONS OUTLOOK 2012, www.oecd.org/finance/privatepensions/

*INTERNATIONAL MIGRATION OUTLOOK 2012,*www.oecd.org/els/internationalmigrationpoliciesanddata/

OECD EMPLOYMENT OUTLOOK 2012, www.oecd.org/employment/employmentpoliciesanddata

SICK ON THE JOB: Myths and Realities about Mental Health and Work (2011), www.oecd.org/els/disability

DIVIDED WE STAND: Why Inequality Keeps Rising (2011), www.oecd.org/els/social/inequality

EQUAL OPPORTUNITIES? The Labour Market Integration of the Children of Immigrants (2010), *via* OECD Bookshop

OECD REVIEWS OF LABOUR MARKET AND SOCIAL POLICIES: ESTONIA (2010), www.oecd.org/els/estonia2010

JOBS FOR YOUTH: GREECE (2010), *www.oecd.org/employment/youth*

JOBS FOR YOUTH: DENMARK (2010), *www.oecd.org/employment/youth*

OECD REVIEWS OF LABOUR MARKET AND SOCIAL POLICIES: ISRAEL (2010), *www.oecd.org/els/israel2010*

JOBS FOR YOUTH: UNITED STATES (2009), *www.oecd.org/employment/youth*

JOBS FOR YOUTH: POLAND (2009), *www.oecd.org/employment/youth*

OECD EMPLOYMENT OUTLOOK: Tackling the Jobs Crisis (2009), www.oecd.org/els/employmentpoliciesanddata/

DOING BETTER FOR CHILDREN (2009), *www.oecd.org/els/social/childwellbeing*

SOCIETY AT A GLANCE – ASIA/PACIFIC EDITION (2009), *www.oecd.org/els/social/indicators/asia*

OECD REVIEWS OF LABOUR MARKET AND SOCIAL POLICIES: SLOVENIA (2009), *www.oecd.org/els/slovenia2009*

INTERNATIONAL MIGRATION OUTLOOK: SOPEMI (2010) *www.oecd.org/els/migration/imo*

PENSIONS AT A GLANCE 2009: Retirement-Income Systems in OECD Countries (2009), www.oecd.org/els/social/pensions/PAG

JOBS FOR YOUTH: FRANCE (2009), *www.oecd.org/employment/youth*

SOCIETY AT A GLANCE 2009 – OECD Social Indicators (2009), *www.oecd.org/els/social/indicators/SAG*

JOBS FOR YOUTH: AUSTRALIA (2009), *www.oecd.org/employment/youth*

OECD REVIEWS OF LABOUR MARKET AND SOCIAL POLICIES: CHILE (2009), *www.oecd.org/els/chile2009*

PENSIONS AT A GLANCE – SPECIAL EDITION: ASIA/PACIFIC (2009), *www.oecd.org/els/social/pensions/PAG*

SICKNESS, DISABILITY AND WORK: BREAKING THE BARRIERS (VOL. 3) – DENMARK, FINLAND, IRELAND AND THE NETHERLANDS (2008), *www.oecd.org/els/disability*

GROWING UNEQUAL? Income Distribution and Poverty in OECD Countries (2008), *www.oecd.org/els/social/inequality*

JOBS FOR YOUTH: JAPAN (2008), *www.oecd.org/employment/youth*

JOBS FOR YOUTH: NORWAY (2008), *www.oecd.org/employment/youth*

JOBS FOR YOUTH: UNITED KINGDOM (2008), *www.oecd.org/employment/youth*

JOBS FOR YOUTH: CANADA (2008), *www.oecd.org/employment/youth*

JOBS FOR YOUTH: NEW ZEALAND (2008), *www.oecd.org/employment/youth*

For a full list, consult the OECD online Bookshop at *www.oecd.org/bookshop*