Organisation for Economic Co-operation and Development

DELSA/HEA(2020)10/REV2

For Official Use

English - Or. English

23 March 2021

DIRECTORATE FOR EMPLOYMENT, LABOUR AND SOCIAL AFFAIRS
HEALTH COMMITTEE

Cancels & replaces the same document of 10 March 2021

DRAFT REPORT ON THE IMPLEMENTATION OF THE OECD RECOMMENDATION ON INTEGRATED MENTAL HEALTH, SKILLS AND WORK POLICY

Mental Health and Work: How Far Have We Come?

Final draft report to be approved, by written procedure, by the Employment, Labour and Social Affairs Committee and the Health Committee

This Cancel and Replace version is issued to reflect the extension of the deadline to approve the document via written procedure.

This report reviews progress of Adherents in the past five years in the implementation and dissemination of the OECD Recommendation on Integrated Mental Health, Skills and Work Policy [OECD/LEGAL/0420] and assesses its continued relevance, including in light of the current COVID-19 crisis. It is a refined version of the draft report shared with the ELSAC and the EDPC in October 2020 [DELSA/ELSA(2020)5/REV1] and the Health Committee in November 2020 [DELSA/HEA(2020)10/REV1], and reflects comments received from Adherents. This draft report also provides suggestions for Adherents to continue to implement, disseminate and use the Recommendation in the coming years. The ELSAC and the HC are invited to approve this draft report as set out in Annex A by **9 April 2021.** The approved report will subsequently be transmitted to the Council who will be invited to note and declassify the report.

Mr. Christopher Prinz: christopher.prinz@oecd.org
Mr. Shunta Takino: shunta.takino@oecd.org

JT03473356

This document, as well as any data and 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.

1. This note presents in Annex A, the final draft report by the Employment, Labour and Social Affairs Committee (ELSAC) and the Health Committee (HC) on the implementation of the Recommendation of the Council on Integrated Mental Health, Skills and Work Policy [OECD/LEGAL/0420] (hereafter the "Recommendation"), and its conclusions regarding the instrument's relevance and dissemination. The report concludes that the Recommendation continues to be relevant, and requires no updating at this stage. In the absence of comments from Adherents by **9 April 2021**, the report, as set out in Annex A, will be considered as approved by the Committee and will be transmitted to the Council, to be noted and declassified.

2. This note also presents Annex B, which provides supporting evidence for the implementation report, and includes indicators to assess the health, labour market and skills outcomes of individuals experiencing mental health conditions. Since Annex B is a living document and not formally part of the implementation report, it does not require approval by the Committee.

Note on language

Using appropriate language in the field of mental health is very important for at least two reasons: to align with rapid ongoing shifts in the use of language that go hand-in-hand with continuing efforts to raise awareness and address stigma and discrimination; and to ensure clear communication of the population groups in focus. As much as possible, appropriate language today should be person-centred, strengths-based, and recovery-focused. The report reflects these important principles. It also aims for language that is inclusive and covers mental health conditions at all levels of severity, from those that have a significant and long-term impact on a person's life and day-to-day functioning, through to those that are highly prevalent in the population but do not necessarily need specialist mental health care. In line with these considerations and to not use language that describes people as their label or diagnosis, this report predominantly uses the terms "mental health conditions" and "mental health issues", whereas the terms "mental illness" and "mental disorder" are avoided. "Mental distress" is also occasionally used in this report as a broader term to refer to an individual experiencing poor mental health, but not necessarily a clinically significant mental health condition.

Background

3. Mental health conditions are widespread and very costly for individuals, employers and society. At any point in time, about 20% of the population experiences a mental health condition. People with mental health conditions have much lower rates of employment, higher rates of unemployment, lower wages and incomes and higher rates of dependence on all types of working-age benefits. The total cost of mental health is 4% of GDP at least, predominantly through lost productivity and less through direct cost of health care. The characteristics and impact of mental health conditions imply that problems cannot be solved in the health system alone but that a holistic policy response is needed that affects all policies.

4. Research conducted by the OECD concluded that a three-way change in policy is needed, characterised by early intervention, the integration of policies and services, and the active involvement of first-line actors – three elements of reform that equally apply for diverse fields of policy. These findings and conclusions were presented at a High-Level Forum in The Hague in March 2015 during which ministers and high-level government officials asked the Secretariat to develop a set of policy principles. Only a few months later, in December 2015, the OECD Council adopted the Recommendation on Integrated Mental Health, Skills and Work Policy, on a proposal by the ELSAC and the HC in consultation with the Education Policy Committee (EDPC) [C(2015)173 & C(2015)173/CORR1; C/M(2015)22].

5. The Recommendation calls for governments to "promote the provision of early and fully integrated services to improve social and labour market outcomes for people with mental health problems" in four thematic areas: health systems, youth support systems, workplace policies, and welfare and social protection systems. It also instructs the ELSAC and the HC to support the efforts of OECD Members and

non-Members having adhered to it (hereafter the "Adherents")[1] to disseminate and implement the Recommendation and to monitor progress and policy development and report thereon to the Council no later than five years following its adoption. This report monitors policy developments in this space.

Methodology

6. The Recommendation instructs the ELSAC and the HC to monitor progress in implementing the Recommendation and developments in integrated mental health, skills and work policy among Adherents. To this end, the Secretariat reviewed progress among Adherents drawing on questionnaires on i) policy developments and ii) dissemination of the Recommendation, and ongoing and previous analysis on integrated mental health, skills and work policy. This was supplemented with the development of indicators presented in Annex B which provides insights into the labour market, skills and health outcomes of individuals experiencing mental health conditions.

7. The findings on the implementation of the Recommendation, which are set out in section 5. , draws primarily on responses to a policy questionnaire, which asked Adherents to identify and describe significant changes in policies introduced since January 2015 that align with the Recommendation in each of the four thematic policy areas that it covers – health care policy, youth policy, workplace policy, and welfare policy. The policy questionnaire was sent to 36 Adherents and, at that time, two active accession countries (Colombia and Costa Rica) in August 2019, and 30 Adherents provided responses.

8. The findings on the dissemination and usefulness of the Recommendation, which are set out in section 4. , are the product of analysis of responses to a follow-up questionnaire sent to Adherents in May 2020. 26 Adherents provided responses to this follow-up questionnaire, which also requested information from Adherents on relevant policy measures that were being taken to respond to the COVID-19 crisis. To further supplement the experiences of Adherents with the perspectives of non-governmental stakeholders, the Secretariat also prepared a separate online questionnaire.

9. Existing publications, notably, *Fit Mind, Fit Job*, provided background information and evidence on the situation of integrated mental health, skills and work policy prior to the adoption of the Recommendation, and evidence collected and analysis conducted as part of the Mental Health Benchmarking Project was also used to enrich the key messages in this report. The Secretariat also analysed data on the health, skills and work outcomes of individuals experiencing mental health conditions and developed indicators covering 32 Adherents to further support the findings presented in this report.

Process

10. A first version of the draft report was shared with the ELSAC in April 2020 [DELSA/ELSA(2020)5]. This draft report, which was referred to as the draft interim report, presented the initial findings on policy developments in integrated mental health, skills and work policy, and Adherents were asked to provide comments. The draft interim report was then updated to reflect these comments and further ongoing work, before being shared with the HC in June 2020 for additional comments [DELSA/HEA(2020)10]. Owing to the COVID-19 crisis, which limited the possibility for in-person meetings, comments were received from both committees by written procedure.

11. Building on the draft interim report, a full draft implementation report was prepared by the Secretariat and shared with the ELSAC [DELSA/ELSA(2020)5/REV1] and EDPC in October 2020

[1] To date, all OECD Members are Adherents to the Recommendation. There are no non-Member Adherents at this stage. Following the Council invitation of 15 May 2020, Costa Rica will become an OECD Member on the date it deposits its instrument of accession to the OECD Convention. Accordingly, it is also included in this report.

[DELSA/ELSA(2020)5/REV1], and with the HC in November 2020 [DELSA/HEA(2020)10/REV1]. The key findings on the implementation and dissemination of the draft report was discussed at the 137th Session of the ELSAC in October 2020, at which Adherents discussed the extent to which the draft report captured relevant policy developments and welcomed the draft report. The draft report was also presented briefly at the 28th Session of the EDPC in November 2020, and the delegates noted the draft report. The Secretariat also invited written comments to the draft report to all three committees, and comments were received from October 2020 to January 2021 from 17 countries and the TUAC.

12. The next step for the ELSAC and the HC is to approve and adopt the draft report, as set out in Annex A, by **9 April 2021**. Once approved, a final version of the report will be transmitted to the Council to be noted and declassified, and made available on the online Compendium of OECD Legal Instruments. Key messages from the implementation report will also be included in a publication to be released later in the year.

Dissemination

13. Responses to the follow-up questionnaire indicate that the extent to which the Recommendation has been disseminated varies significantly among Adherents, as well as across different stakeholders within Adherents, and that significant room remains to increase awareness of the Recommendation, especially among non-government stakeholders. The Secretariat has contributed to dissemination efforts through its publications and events, as well as through preparing a flyer to promote dissemination of the Recommendation by Adherents. A country review for New Zealand, conducted in 2018, demonstrates the usefulness of the Recommendation as a basis for policy reform. Possible measures to strengthen the dissemination of the Recommendation and encourage better use of the Recommendation in policy development going forward are also discussed in the draft report.

Summary and conclusions

14. Since the adoption of the Recommendation, Adherents have increasingly focused on integrating mental health policies with education, skills, social and health policies. Moreover, since the adoption of the Recommendation, many Adherents have put in place measures to increase public awareness surrounding mental health, which is a key foundation to translating integrated mental health policies into more timely and appropriate mental health interventions at the working level.

15. However, further progress is still needed to transform progress at the strategy level into more integrated practices at the working level, with structural barriers and a shortage of financial resources continuing to hamper efforts to develop integrated mental health policies. Progress is also uneven across the four thematic areas identified by the Recommendation, with the clearest examples of integrated practices being seen in youth policies, whereas integrated practices remain rare in social protection and welfare policies. Workplace and health policies take an intermediary position. Within each of the thematic areas, gaps in policy are identified that Adherents should consider addressing, and examples of good practices are provided throughout to offer insight into how Adherents may wish to put in place more integrated policies.

16. The challenges that Adherents face in implementing integrated mental health, skills and work policies illustrate the continued importance of taking into account the timing (the "when") and modalities (the "what" or "how") of policy intervention, and in the actors needed for policy change (the "who"). The draft report finds that while mental health policies increasingly provide timelier intervention (the "when") and training of front-line actors in mental health is widespread (the "who"), the actual working level integration of mental health policies and services (the "what" or "how"), still continues to lag behind. Based on the policy experiences since the adoption of the Recommendation, the draft report also suggests

Adherents can be categorised as falling under certain stages in their integrated mental health, skills and work policy.

17. The draft report also confirms the continued importance and relevance of the Recommendation, especially in light of the ongoing COVID-19 crisis, and considers the possible long-term impacts of the crisis on the integrated mental health, skills and work policy and the application of this Recommendation going forward. The draft report concludes with a consideration of possible next steps that both Adherents and the Secretariat can take to strengthen the implementation and dissemination of the Recommendation in the years ahead.

Annex A. Draft report on the Implementation of the Recommendation of the Council on Integrated Mental Health, Skills and Work Policy

MENTAL HEALTH AND WORK: HOW FAR HAVE WE COME?

Table of contents

Annex A. Draft report on the Implementation of the Recommendation of the Council on Integrated Mental Health, Skills and Work Policy 6

1. Background 8
1.1. Why integrated mental health, skills and work policy matters 8
1.2. When, how and who: three key elements for an integrated mental health, skills and work policy 9

2. Methodology 13

3. Process 15

4. Dissemination and use of the Recommendation 16
4.1. Dissemination efforts should be reinforced 16
4.2. The Recommendation could be used more to inform policy developments 18
4.3. Developing tools to strengthen dissemination and use of the Recommendation 21
Annex 4.A. List of selected dissemination activities by the Secretariat 22

5. Implementation of the Recommendation 23
5.1. Mental health plans: placing strategic importance on integration 23
5.2. Raising awareness and addressing stigma: campaigns remain prevalent across Adherents 27
5.3. Integration of mental health policy at the working level across the four thematic areas 31

6. Summary and conclusions 55
6.1. Key conclusions on the implementation of the Recommendation 55
6.2. Key conclusions on the dissemination and use of the Recommendation 60
6.3. Continued Relevance 60
6.4. Next steps 63

Annex B. Comparative indicators for integrated mental health, skills and work policy 65

References 90

1. Background

1.1. Why integrated mental health, skills and work policy matters

18. Mental health affects the way we think, feel, behave and interact with others in our daily lives and good mental health is a foundation for fulfilling and productive lives. Yet at any given moment, one in five people in the working-age population is experiencing a mental health condition, and one in two of us will suffer a period of poor mental health during our lifetimes. While we may not be experiencing a mental health condition ourselves, we may do so in the future, or we will know of a family member, friend, colleague or co-worker that is experiencing a mental health condition.

19. Mental health is critical throughout one's lifetime from childhood to old age. For children, adolescents and young people, mental health issues can affect education and future labour market outcomes. For adults of working age, mental health affects performance at work and in some cases, poor mental health can result in prolonged sick leave, unemployment and labour market exit. For the elderly, poor mental health affects participation in society and is associated with loneliness. Across the OECD, students indicating mental distress are 35% more likely to have repeated a grade at school, and among the working age-population, individuals with mental health issues are 20% less likely to be in employment.

20. Individuals with a mental health condition are also around 50% more likely to be receiving benefits. The OECD's long-standing research, starting with *Sick on the Job? Myths and Realities about Mental Health and Work* (OECD, 2012[1]), has consistently found clear evidence that more must be done to improve the inclusion of individuals experiencing mental health conditions in our education and youth systems, labour markets and society more generally.

21. There also remains widespread stigma surrounding mental health, and individuals experiencing mental health issues are often seen as being unable to work, learn or live together with other members of society, resulting in their exclusion. Promoting mental health in all areas of societies including health systems, youth support systems, workplaces, and welfare and social protection systems thus remains crucial to cultivating a culture of acceptance of mental health issues. This could help to address some of the myths that still surround mental health issues, and create an accepting environment for individuals to seek support and treatment.

22. Building on this, the OECD conducted country reviews culminating in the publication of *Fit Mind, Fit Job: From Evidence to Practice in Mental Health and Work* (OECD, 2015[2]), which was launched at a High Level Policy Forum on Mental Health and Work hosted by the Dutch government in March 2015. At this Forum, participating ministers and government officials called on the OECD to develop policy principles with a particular focus on the development and dissemination of integrated skills, mental health and work policies. In December 2015, this work culminated in the adoption by the OECD Council of the Recommendation on Integrated Mental Health, Skills and Work Policy [OECD/LEGAL/0420] (hereafter, the "Recommendation") on the proposal of the Employment, Labour and Social Affairs Committee (ELSAC) and the Health Committee (HC) in consultation with the Education Policy Committee (EDPC) [C(2015)173 & CORR1]. The focus of this report is to assess the implementation of this Recommendation across Adherents five years after its adoption as instructed by recommendation (8c).

Box 1.1.Overview of policy developments in integrated mental health, skills and work policy

The Recommendation and the OECD's work on integrated mental health, skills and work policy is in line with the changing international policy environment. In 2013, the European Union launched The Joint Action for Mental Health and Well-being, aimed at building a framework for action in mental health policy at the European level and building on previous work developed under the European Pact for Mental Health and Well-being. The Joint Action addresses five areas, including mental health promotion in schools, mental health promotion in workplaces, and mental health in all policies.

Soon after, in 2014, the World Health Organisation released a publication on the social determinants of mental health which made the case that all sectors such as education, welfare and housing among others need to be actively involved and work together to promote mental health (WHO and Calouste Gulbenkian Foundation, 2014[3]). This elaborated on the need for countries to address the social determinants of health that was raised in the WHO's Comprehensive Mental Health Action Plan 2013-2020. The work of both the European Union and the WHO is thus aligned with the OECD's emphasis on integration and the need to look beyond the health system to assess how well countries are addressing mental health in their policies.

Moreover, in parallel with the Recommendation, mental health has become a core component of the 2015 Sustainable Development Goals, further reinforcing the message that mental health is crucial for the overall development of our societies. SDG target 3.4 calls on countries to reduce premature mortality not only through prevention and treatment of non-communicable diseases, but also through promoting mental health and wellbeing. Just as importantly, policy reforms in mental health will be crucial to achieving many of the other SDG targets that relate to employment, education and reduced inequalities. This report thus contributes to the broadening of the concept of mental health as envisioned by the SDGs, by drawing attention to the importance of mental health in achieving good education, work and social outcomes.

Building on the SDGs, in 2018, the Lancet Commission on Global Mental Health elaborated on the interlinkages of mental health, noting that "all countries can be thought of as developing countries in the context of mental health" (Patel et al., 2018[4]). By adopting a stage-based approach to the development of a fully integrated mental health, skills and work policy, this report provides countries with a framework to further their reforms of mental health policy using the Recommendation as a basis and aspire to become developed nations in the context of mental health.

1.2. When, how and who: three key elements for an integrated mental health, skills and work policy

23. *Fit Mind, Fit Job* concluded that to develop an integrated mental health, skills and work policy, countries need to take into account **when** intervention or support is taking place, **what** or **how** such intervention or support looks like, and **who** is carrying out the intervention. The report argued that too often, interventions come too late, from the wrong person with key stakeholders left out, and in a siloed manner that failed to reflect the integrated nature of challenges of mental health policy. This is reflected in the Recommendation, which calls for a shift in these three aspects of integrated mental health, skills and work policy, namely in the timing (the "when") and modalities (the "what" or "how") of policy intervention, and in the actors needed for policy change (the "who"). These three interlinked elements, which underline the Recommendation, will remain crucial going forward.

1.2.1. When: the importance of early intervention and timely treatment

24. The Recommendation calls for early identification, intervention and support for individuals with mental health issues in all systems and policies. The inclusion of the thematic areas of youth and workplace policies in the Recommendation is a reflection of this very emphasis on timely intervention, as workplaces, schools and universities are often the first places where symptoms of mental health issues arise. Moreover, evidence suggests that measures to address mental health issues are far more effective if put in place when students are in schools rather than after they have stopped attending. Similarly, supporting people to stay in work is far more effective than helping them return to a job after unemployment or sickness absence, and this also applies to those with mental health conditions.

25. Recommendations (2c) and (2d) seek to promote more timely intervention for children and young people by calling for timely access to co-ordinated and non-stigmatising support for this group, and greater investment in prevention of early school leaving. With regard to the workplace, recommendation (3a) calls for workplace psychosocial risk assessment and prevention, while recommendations (3d) and (3e) call for measures to encourage return-to-work and prevent long-term sick leave.

26. Even after an individual with mental health conditions drops out of the labour market and services and social benefits kick in, intervention is often provided too late, resulting in further detachment from the labour market and the risk of worsening of mental health conditions. This is why recommendation (4d) calls for the integration of mental health treatment into the public employment service. Effective early treatment can also help to reduce preventable disability benefits as called for by recommendation (4a).

27. Another challenge is the lack of early action in the health system to help people reconnect with school or work. Even after an individual has first seen a mental health specialist, or has discussed mental health problems with a general practitioner, in many Adherents, they then face long waiting times to receive the care, treatment and support they require, and where such support is provided, it may not have an education or employment focus. This is why recommendation (1b) calls for the promotion of timely access to effective treatment of mental health conditions in both community and primary care settings.

1.2.2. What and how: addressing the interlinkages of mental health with work, skills and the welfare and social protection system

28. The Recommendation recognises the importance of integrated mental health, skills and work policy to provide better support for individuals with mental health conditions and promote better mental health among the general population. The core premise of the Recommendation is thus that action is required in a range of policy fields – including health, youth, labour market and social policy. Yet as *Fit Mind, Fit Job* noted, far too often, mental health policies have been delivered in silos focused narrowly within the health sector, with only occasional mention in other areas such as employment and education.

29. For such an approach to be planned and delivered, decision-makers in each of the thematic areas need to prioritise integration. In the mental health care system, there needs to be greater focus on the employment dimension, with recommendation (1c) calling for the introduction of employment outcomes as a measure to evaluate performance. Recommendation (1e) calls on medical professionals to address issues at work and school – such as sickness absence and truancy – that are often closely associated with mental ill-health. In youth support systems, as recommendation (2c) emphasises, appropriate support structures need to be put in place that link youth and community centres and educational institutions at all ages – from pre-school, school and higher education institutions – to assistance through treatment and counselling that may primarily be offered in the health system.

30. The importance of integrated mental health policies in the workplace and in social protection systems is made clear in the Recommendation. The working lives of individuals have a profound impact on their mental health and meaningful work is often an important contributing factor to recover from mental health conditions. This is why the Recommendation calls for greater enforcement and promotion of

psychosocial risk assessment in the workplace with the support of occupational health services (3a) and encourages employers to prevent overuse of sick leave by facilitating dialogue not only between employees, employers and their representatives, but also with physicians and mental health practitioners in the health system. The Recommendation also calls for the integration of mental health treatment into employment services through the delivery of evidence-based psychological counselling combined with vocational support for individuals with mild-to-moderate mental health conditions (4d).

1.2.3. Who: the role of front-line actors in identifying mental health conditions and ensuring access to support

31. The Recommendation reflects the key finding from *Fit Mind, Fit Job* suggesting that progress on integrated mental health, skills and work policy cannot be achieved if the task of supporting individuals with mental health problems is left to specialist mental health care workers and institutions alone. The Recommendation therefore calls for Adherents to harness the key role that front-line actors across all of society – especially but not only teachers, line managers, general practitioners and employment service caseworkers – have in identifying mental health conditions and addressing its impact on students, workers, patients and jobseekers. This relates to both training existing front-line actors and ensuring that there are individuals with experience and understanding of mental health issues in schools, universities, workplaces and in the social protection system. The importance of competence-building also closely relates to timelier intervention (the "when"), as in the absence of adequately trained front-line actors, possible signs of mental health issues are likely to go unnoticed resulting in late intervention and support.

32. In health systems, the Recommendation calls for the expansion of mental health competence among workers in the primary care sector such as general practitioners, occupational health specialists, nurses and family doctors (1b). This reflects the importance of these figures as gatekeepers within the health system to specialist health services such as treatment from a psychiatrist. Meanwhile, in youth support systems, the Recommendation calls on Adherents to not only improve awareness and understanding of mental health issues among education professionals and families of students, but also to ensure there is an adequate number of individuals in the education system with knowledge of psychological and behavioural adaptations that are crucial to the learning process (2b).

33. There are also explicit references to the importance of the mental health competence of front-line actors in both workplaces and social protection systems. In workplaces, raising competence is an important part of broader anti-stigma policies at work with the Recommendation calling on Adherents to promote the development of guidelines for line managers, human resource professionals and worker representatives such that employees experiencing mental health issues can get appropriate support (3c, 3d). It is also vital to invest in mental health competence and training for caseworkers, social workers and vocational counsellors who are responsible for administering employment services and social benefits (4c).

Box 1.2. What is meant by “mental health competence”?

The term “mental health competence” is used throughout this report in reference to the need to train front-line actors in the health system, workplace, education institutions, public employment services, and beyond. The broad term “competence” is used to reflect the need for front-line actors to not only understand mental health as a subject, but also to know what next steps may be appropriate to take.

Mental health competence should thus be broadly understood as consisting of three elements:

- **Understanding of the subject of mental health** – front-line actors need to be trained in and develop an understanding of what mental health is, how to communicate or talk about mental health in a non-stigmatising manner, and learn about behavioural changes that could indicate potential mental health conditions. Front-line actors may be able to acquire this aspect of mental health competence through public awareness campaigns.
- **Understanding of the interlinked nature of mental health** – front-line actors need to be trained in and develop an understanding of how broader factors such as workplace and school environments, as well as personal and family circumstances, can influence mental health, and thus how their actions as front-line actors is vital in supporting the mental health of the general population.
- **Capacity to take appropriate and timely course of action** – front-line actors need to be aware of the options available to them to support an individual exhibiting mental distress or symptoms of potential mental health conditions, and then have the capacity and skills to take an appropriate and timely course of action. Front-line actors can only acquire this aspect of mental health competence through training.

The exact nature and level of competence in mental health required will differ from position-to-position, as will the options available in terms of courses of action and interventions. To provide an example, general practitioners may be expected to be able to distinguish between episodes of mental distress and above-threshold mental health conditions, and thus use their competence to decide whether an individual may benefit from a referral to a specialist. By comparison, managers in the workplace may be expected to use their competence to identify potential symptoms of mental distress or mental health issues which may be noticeable through behavioural changes at work such as sudden low productivity, unexplained absences from work, or repeated lateness. While a manager is unlikely to be able to refer an employee directly to a mental health specialist, they could take steps such as checking-in more regularly or asking executives in the firm of the possible options available to support the employee.

2. Methodology

34. Since the adoption of the Recommendation, the OECD has continued its work on integrated mental health, skills and work policy, including the monitoring of policy developments. The rest of this section explains how the Secretariat has carried out its first OECD-wide assessment on the implementation and dissemination of the Recommendation through a mix of questionnaires to monitor policy developments and the development of indicators, presented in Annex B, to monitor actual progress in improving social, educational and labour market outcomes of individuals experiencing mental health issues.

35. In order to assess the implementation of the Recommendation across Adherents, the Secretariat collected information on policy experiences through a questionnaire (hereafter the "policy questionnaire") sent to 36 Adherents and, at that time, two active accession candidate countries (Colombia and Costa Rica) in August 2019. 30 countries provided responses to this policy questionnaire (hereafter "the Respondents").[2] The policy questionnaire asked Adherents to describe significant changes in policies introduced since January 2015 that align with the Recommendation in each of the four thematic policy areas that it covers – health care policy, youth policy, workplace policy, and welfare policy. The responses from the policy questionnaire provide much of the evidence used to prepare Chapter 5. on the implementation of the Recommendation.

36. A further questionnaire (hereafter "follow-up questionnaire") was sent to Adherents in May 2020 to assess their efforts to disseminate the Recommendation, and gain an insight into the level of awareness of the Recommendation among stakeholders and the perceived usefulness and relevance of the Recommendation. The follow-up questionnaire also included an additional section requesting information on measures taken by Adherents to support individuals with mental health conditions during the COVID-19 crisis. 26 Adherents provided responses to the follow-up questionnaire.[3]

37. To capture the perspectives, experiences, and findings of non-government stakeholders, the Secretariat prepared a separate online questionnaire for non-governmental stakeholders in mental health policy (hereafter "non-government questionnaire"). Adherents were asked to share this questionnaire with relevant non-government stakeholders – i.e. organisations or institutions identified as playing a significant role in the development and implementation of integrated mental health, skills and work policy. Only eight non-government stakeholders from four different Adherents provided responses to the non-government questionnaire.[4]

---

[2] 21 countries provided comprehensive answers to all questions (Australia, Austria, Canada, Colombia, Costa Rica, Czech Republic, Denmark, Estonia, Finland, France, Hungary, Ireland, Latvia, Lithuania, Netherlands, New Zealand, Norway, Poland, Sweden, Switzerland, United Kingdom) and another 9 provided partial responses (Belgium Greece, Italy, Japan, Korea, Mexico, Spain, Turkey, United States).

[3] 26 countries provided comprehensive or partial responses to the follow-up questionnaire (Australia, Austria, Belgium, Canada, Colombia, Costa Rica, Czech Republic, Denmark, Estonia, Finland, France, Greece, Hungary, Ireland, Italy, Japan, Korea, Latvia, Lithuania, Mexico, New Zealand, Norway, Poland, Sweden, Switzerland, Turkey)

[4] Responses to the non-government questionnaire came from Austria, Canada, Ireland and Norway.

38. As set out in Annex B, the Secretariat has also developed a series of indicators across 32 of 37 OECD countries that provide insights into the differences in labour market, education and social outcomes of individuals with and without mental health issues drawing on indirect measures of mental health status that are commonly used in population surveys. Although these indicators may not yet provide a full picture of progress made in countries since the adoption of the Recommendation, they provide a useful snapshot of the performance of countries. For a few countries, data from before and since the adoption of the Recommendation are also already available (Belgium, Netherlands, Switzerland and the United States), although such data is too limited at this stage to draw conclusions on progress across Adherents based on indicators. The indicators set out in Annex B are not formally part of the draft report, but serve to provide evidence and information to supplement the conclusions and key findings. The indicators are to be considered a living document and may be subject to updates as new data becomes available.

3. Process

[This section will be updated to reflect the final steps in the process after the approval of the draft report.]

39. A first version of the draft report was shared with the ELSAC in April 2020 [DELSA/ELSA(2020)5]. This draft report, which was referred to as the draft interim report, presented the initial findings on policy developments in integrated mental health, skills and work policy, and Adherents were asked to provide comments. The draft interim report was then updated to reflect these comments and further ongoing work, before being shared with the HC in June 2020 for additional comments [DELSA/HEA(2020)10]. Owing to the COVID-19 crisis, which limited the possibility for in-person meetings, comments were received from both committees by written procedure. A total of 11 Adherents provided comments to either or both versions of the draft interim report.

40. Building on the draft interim report, a full draft implementation report was prepared by the Secretariat and shared with the ELSAC [DELSA/ELSA(2020)5/REV1] and EDPC in October 2020 [DELSA/ELSA(2020)5/REV1], and with the HC in November 2020 [DELSA/HEA(2020)10/REV1]. The key findings on the implementation and dissemination of the draft report was discussed at the 137th Session of the ELSAC in October 2020, at which Adherents discussed the extent to which the draft report captured relevant policy developments and welcomed the draft report. The draft report was also presented briefly at the 28th Session of the EDPC in November 2020, and the delegates noted the draft report. The Secretariat also invited written comments to the draft report to all three committees, and comments were received from October 2020 to January 2021 from 17 countries and the TUAC.

41. The next step for the ELSAC and the HC is to approve and adopt the draft report, as set out in Annex A, by **9 April 2021**. Once approved, final version of the report will be transmitted to the Council to be noted and declassified, and made available on the online Compendium of OECD Legal Instruments. It is proposed that the Council invites Adherents to continue to support the implementation and dissemination of the Recommendation, and key messages from the implementation report will also be included in a publication to be released later in the year.

4. Dissemination and use of the Recommendation

4.1. Dissemination efforts should be reinforced

42. The Recommendation invites the Secretary-General and Adherents to disseminate the Recommendation. While a number of dissemination efforts and measures have taken place, there is scope to do more, especially in reaching out to and involving non-governmental stakeholders. Adherents may wish to consider if they would be interested in the Secretariat developing tools to help strengthen the dissemination of the Recommendation.

43. A primary means of dissemination by the Secretariat has been the preparation of a country review for New Zealand published in December 2018 titled Mental Health and Work: New Zealand, which showed the value provided by the Recommendation as a framework for informing best practices in integrated mental health, skills and work policy in Adherents. Further country reviews would be useful to bring the Recommendation to life and show how the principles outlined can be used to advance integrated policy and service provision.

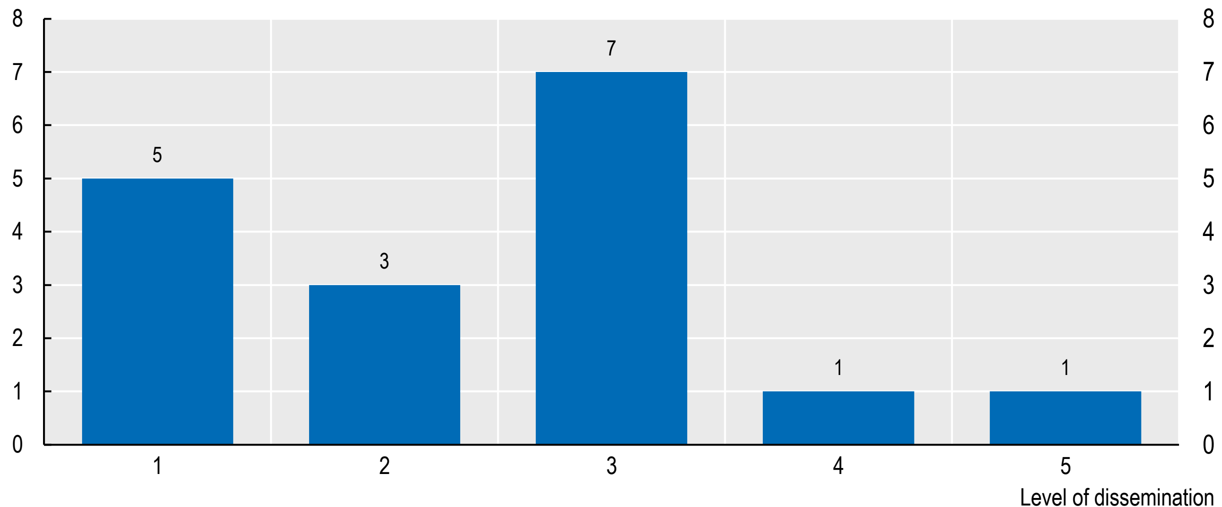
44. The Recommendation has also been disseminated through flagship events organised by the OECD. This includes, most notably, the OECD Employment and Labour Ministerial and High-Level Policy Forum held in Paris in January 2016, at which ministers welcomed the Recommendation and recognised the ways in which health, education, employment and social policies interact and together will play a major role in improving the employment opportunities for people with mental health conditions (OECD, 2016[5]). The OECD also supported the United Kingdom, together with the World Health Organisation, in hosting the inaugural Global Ministerial Mental Health Summit in 8 October 2018. For the event, the OECD also prepared a flyer summarising the key messages from the Recommendation, which was distributed to attendees and is available online. The Secretariat will continue to promote the Recommendation through events organised by the OECD.

45. The Secretariat has also promoted and disseminated the Recommendation through smaller-scale events such as launch events and expert meetings, and has also drawn on the Recommendation in OECD publications on healthcare, labour market and social policy. Notable publications referring to the Recommendation include *Health at a Glance: Europe 2018: State of Health in the EU Cycle* (2018[6])and *Good Jobs for All in a Changing World of Work: The OECD Jobs Strategy* (2018[7]). A list of dissemination activities conducted so far by the Secretariat is available in Annex 4.A.

46. In the follow-up questionnaire, Adherents were asked to note how widely the Recommendation has been disseminated in their country on a scale of 1 to 5, with a rating of ‘5’ meaning that the government considers all relevant administration units, stakeholders and the public in general have been informed about the Recommendation. The results point to substantial variation across Respondents to the follow-up questionnaire in the degree of dissemination efforts as shown in Figure A.4.1. Only two Respondents to the follow-up questionnaire (Colombia and Estonia) responded with a score of ‘4’ or ‘5’, with the average score across all Respondents being 2.4.

Figure A.4.1. Self-assessed level of dissemination of the Recommendation by Respondents to the follow-up questionnaire

Scale of 1 to 5, with a score of '5' meaning that all relevant administration units, stakeholders and the public in general have been informed about the Recommendation



Note: Of the 26 countries Respondents to the follow-up questionnaire, 8 provided no response to the question on the level of dissemination and 1 country provided an ambiguous answer. The distribution shown is based on the self-assessment of the remaining 17 Respondents to the follow-up questionnaire.
Source: OECD follow-up questionnaire on the Recommendation of the Council on Integrated Mental Health, Skills and Work Policy (2020[8]).

47. Few Respondents have information on the Recommendation available on their websites. In the responses to the questionnaire, only two Respondents said that a translation of the Recommendation had been made available and only four noted that they had made the Recommendation available on a government website.[5] An unofficial translation into Spanish has been prepared by Peru – which is not among the Adherents to the Recommendation – and is available on their government website. This suggests that non-Member countries that are currently not Adherents to the Recommendation may also be interested in adhering to or finding out more about the Recommendation. Further translations of the Recommendation may help promote its use at the working level. The Secretariat will therefore explore taking measures to facilitate translation of the Recommendation into other languages by third parties and include these unofficial translations on the webpage of the Recommendation on the online Compendium of OECD Legal Instruments.

48. Adherents were also asked to assess the level of awareness of the Recommendation among a set of relevant stakeholders – policymakers and government agencies, the non-governmental sector, the research sector, public employment services, the health sector and health professionals, employer representatives and the education sector. A detailed discussion on how the Recommendation can be disseminated to the non-governmental sector is shared in Box 4.1. The responses to this question suggested that there is significant room to increase awareness of the Recommendation in all areas, with

[5] The four Respondents that responded saying that the Recommendation had been made available on their website were Costa Rica, France, Lithuania and New Zealand. In New Zealand, an official government response to the country review was published on the Ministry of Health's website. Japan and France were the only Adherents that said that the Recommendation had been translated. An official French version was already prepared by the Secretariat, and no translation into Japanese was available online.

only six Respondents to the follow-up questionnaire stating that any stakeholder had a high level of awareness of the Recommendation.[6] Based on the follow-up questionnaire, the lack of awareness of the Recommendation seems to be greatest in the non-governmental sector, public employment services, employer representatives and the education sector.

Box 4.1 Disseminating the Recommendation with the non-government sector

The responses to the follow-up questionnaire clearly show that the Recommendation is not well known outside of government agencies, and that further efforts are required by the Secretariat and Adherents to reach out and disseminate the Recommendation among non-government stakeholders. The non-government stakeholder questionnaire, which was shared by the Secretariat with adherents to be passed on to relevant non-government stakeholders, only received responses from eight stakeholders. One response from the non-governmental sector was particularly revealing with a respondent stating that they became aware of the Recommendation for the first time when they were invited by their government to fill out the survey. There appear to be few, if any, examples of explicit use of the Recommendation by non-government stakeholders. This is in sharp contrast to experiences during a number of workshops and seminars in which a number of such stakeholders, when they learned about the Recommendation, expressed how useful they could or would be for their daily work and to progress awareness, procedures and policies.

The importance of non-government stakeholders is clear across Adherents in the development and implementation of mental health policy. Increasingly, NGOs not only raise awareness of mental health and thus destigmatise the issue, but they are also often contracted by governments to deliver integrated mental health services. New Zealand's *He Ara Oranga Report of the Government Inquiry into Mental Health and Addiction*, for example, recognises not only that the country "already [relies] heavily on the NGO sector" but that that they "expect this reliance will increase." Efforts to increase dissemination of the Recommendation – by both the Secretariat and Adherents – would be a critical step forward in putting into place more integrated mental health, skills and work policies.

To this end, the Secretariat will seek to disseminate the Recommendation through Business at OECD and the Trade Union Advisory Committee to the OECD (TUAC), given the official role of these institutions as advisory bodies of the Organisation. The Secretariat will also seek to work with networks of non-governmental organisations with an emphasis on stakeholders identified as having low levels of awareness. Given the important role played by NGOs, Adherents are also strongly encouraged to inform all relevant stakeholders about the Recommendation.

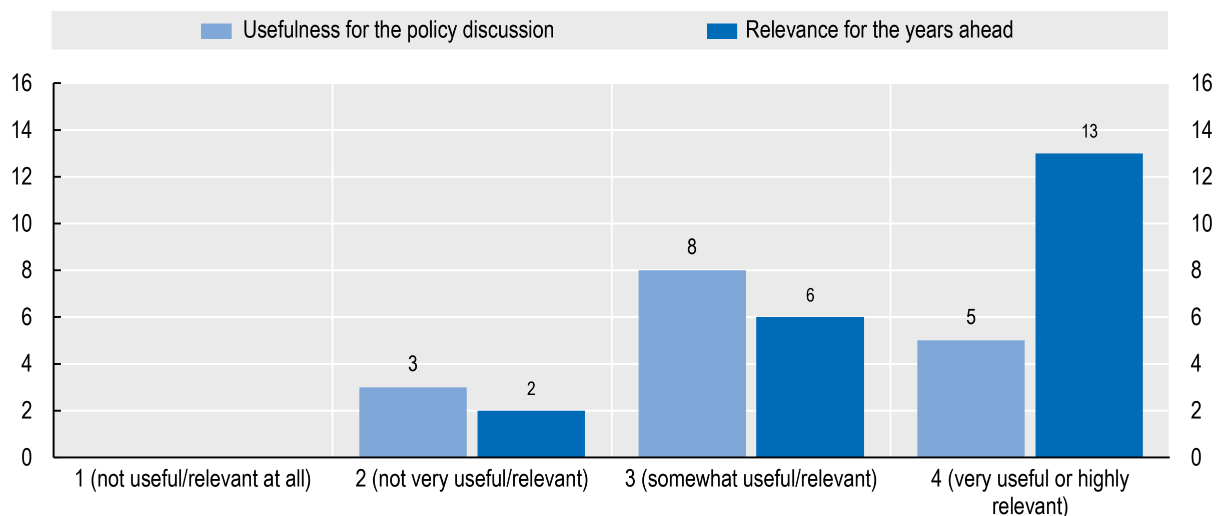
4.2. The Recommendation could be used more to inform policy developments

49. In the follow-up questionnaire, Adherents were also asked how useful the Recommendation had been so far in policy discussions and in reforming systems and policies. A majority of the responses stated that the Recommendation had so far been "somewhat useful" or "very useful" in policy discussions as shown in Figure A.4.2. The Recommendation was seen as being even more useful for guiding policy over the years ahead, with the majority of responses stating that it would be "highly relevant".

[6] This was for policymakers and government agencies in Australia, Czech Republic, Estonia, France and New Zealand, for the health sector in Hungary, and for all stakeholders in Colombia. Only Colombia said awareness was "high" in the non-governmental, research, and education sector public, employment services, and employer representatives.

50. Several Respondents to the follow-up questionnaire were unable to specify how useful the Recommendation had been in advancing policy reform or how relevant they considered the Recommendation for the years ahead. Some Respondents explicitly mentioned that they were "not able" (without specifying why) to answer questions on relevance or usefulness, while one Respondent explicitly noted that it was "difficult to indicate whether the OECD Recommendation [had been] used." The Secretariat will build on the results of this consultation exercise to reach out to Adherents about the relevance of the Recommendation and the support that can be offered for designing and implementing reforms in mental health policy.

Figure A.4.2. Self-assessed level of usefulness of the Recommendation by Respondents to the follow-up questionnaire and the relevance of the Recommendation for the years ahead



Note: Of the 26 Respondents to the follow-up questionnaire, 10 provided no response or an ambiguous answer to the question on usefulness, and 5 provided no response to the question on relevance for the years ahead. The distribution shown is based on the self-assessment of the Respondents to the follow-up questionnaire that provided responses to the question on usefulness so far and/or relevance for the years ahead.
Source: OECD follow-up questionnaire on the Recommendation of the Council on Integrated Mental Health, Skills and Work Policy (2020[8]).

51. A number of Respondents to the follow-up questionnaire were able to give specific examples of where the Recommendation has been used as a basis for policy reform. In New Zealand, the Recommendation and the country review have been used together with the *Government Inquiry into Mental Health and Addiction* to inform further reform of mental health policy in a broad sense. The example of New Zealand also illustrates the value of country reviews to apply the guiding principles of the Recommendation in a manner that takes into account national circumstances as described in Box 4.2. Such country reviews can act as a vehicle to translate the Recommendation into concrete policy actions that bridges the apparent gap between the usefulness and relevance of the Recommendation.

52. Among the few Respondents to the follow-up questionnaire who responded saying that the Recommendation had been "very useful", policy developments tend to be closely aligned with the Recommendation, although no specific reference is made to the Recommendation itself. This is most visible in the National Mental Health Strategy in Colombia, which closely reflects the key tenets of the Recommendation. Similarly, Estonia stated that the Recommendation is being used in the development of the Green Paper on Mental Health. The Recommendation is also explicitly mentioned in Australia, where a report on policies to support the mental health of veterans uses the Recommendation's guiding principles (Department of Veterans' Affairs, 2019[9]) and in Scotland (United Kingdom), where the Recommendation is referenced in a report by the Taskforce on Children and Young People's Mental Health (2018[10]). While

there may be other Adherents where the Recommendation has been used to inform policy developments, the Secretariat has not been informed of such examples in the responses to the follow-up questionnaire.

53. The Recommendation is also contributing to policy developments through other intergovernmental organisations. At Out of the Shadows: Making Mental Health a Global Priority, an event in April 2016 with ministerial level attendees, the World Bank Group committed to using the Recommendation "to hold countries accountable in their commitment to developing more integrated, cross-sectoral mental health policy approaches" (World Bank Group and World Health Organisation, 2016[11]).

Box 4.2. The Recommendation and policy developments in New Zealand

In March 2017, the Ministry of Health and the Ministry of Social Development of New Zealand jointly commissioned a country review by the OECD to evaluate New Zealand's approach to addressing mental health and work policy challenges. The report, *Mental Health and Work: New Zealand*, published in December 2018, was the first to review policies against the Recommendation and discussed through a mental health lens, the transition from education to employment, workplace policies and practices, employment services for jobseekers, long-term sickness absence and the capacity of the health system.

In parallel to this OECD report, New Zealand conducted its own *Government Inquiry into Mental Health and Addiction*, which included widespread public consultation. During this consultation process, the OECD also submitted its own preliminary findings to the Inquiry Panel. In November 2018, the inquiry published He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction, which identified many similar challenges to those expressed in the OECD report. In May 2019, the Government of New Zealand formally responded to the recommendations from *He Ara Oranga*. This included a response to the OECD's *Mental Health and Work* report to ensure the OECD's recommendations also feed into subsequent policy developments. In the response, the Government accepted or accepted "in principle", 18 of the 20 recommendations made by the OECD and noted that the overall direction of the report aligns with the Inquiry's findings (Ministry of Health, 2019[12]).

Mental health and addiction has been placed high on the agenda of the current Government. In Budget 2019, dubbed the Wellbeing Budget, there was a record NZD 1.9 billion commitment over four years to a cross-government package of initiatives to improve support for New Zealanders' mental wellbeing (New Zealand Treasury, 2019[13]). The areas of funding closely reflected the key principles outlined in the Recommendation. For example, the 2019 Budget allocated NZD 455 million over four years to a new programme to expand access to and choice of mental health and addiction support for individuals with mild-to-moderate needs. The programme includes dedicated funding streams for *kaupapa Māori*, Pacific and youth-specific services, and aims to provide access to 325 000 people by 2023/2024. The Budget allocates funding to reach 5 600 extra secondary students through expanding school-based health services, which aligns with the Recommendation's call to promote timely access to co-ordinated and non-stigmatising support for children and youth living with mental health conditions. The Ministry of Social Development has also received funding to expand Individual Placement and Support, to increase access to phone and online mental health support for individuals claiming benefits, and to strengthen the mental health competence of staff administering the social protection system.

4.3. Developing tools to strengthen dissemination and use of the Recommendation

54. In the follow-up questionnaire, Adherents were asked to choose from a number of possible measures they would like to see the OECD take moving forward, to strengthen the dissemination of the Recommendation and to support Adherents in implementing the Recommendation. Noting that around a third of the Respondents to the follow-up questionnaire (9 out of 26) did not choose any of the proposed measures, the results were as follows:

- Organisation of workshops at the domestic and/or international level (9 Respondents)
- Preparing flyers and dissemination tools (7 Respondents)
- Development of adequate indicators (13 Respondents)
- Setting up of an informal group of experts (8 Respondents)

55. The Secretariat will consider whether such activities may be feasible to support the dissemination and implementation of the Recommendation going forward. Workshops, at national or international level, could help support Adherents in implementing and disseminating the Recommendation, and a number of Adherents have provided additional written comments expressing their interest in participating in such workshops to help promote peer learning between countries and to tailor the application of the Recommendation to specific national circumstances. The responses also indicate the interest of Adherents in the establishment of a group of experts, and thus the Secretariat will consider whether this is feasible, and if so, how such a group of experts could be implemented in practice without duplicating the functions of existing expert and working groups.

56. The Secretariat will also consider developing additional flyers to build on the existing flyer prepared in 2018, which provided an overview of the Recommendation. These additional flyers could, for example, provide practical tools for implementing integrated mental health, skills and work policy at the working level in each of the four thematic areas, or provide information to Adherents on how the Recommendation can be used to guide mental health policy during and beyond the COVID-19 crisis. In preparing such flyers, the Secretariat will also be able to draw on ongoing work on the implications of the COVID-19 crisis for integrated mental health, skills and work policy.

57. The Secretariat has already developed a range of indicators on the health, education, social and labour market outcomes for individuals experiencing mental health issues, which are presented (including details on measurement and definitions) in Annex B. These indicators will be updated regularly and will serve the dual purpose of providing Adherents with a means to assess progress in implementing the Recommendation, and as a tool to help disseminate the Recommendation.

Annex 4.A. List of selected dissemination activities by the Secretariat

58. Activities undertaken by the Secretariat to promote and disseminate the Recommendation include, among others:

- September 2015: the Secretariat presented the Recommendation and ongoing work on integrated mental health, skills and work at the launch of the European Alliance for Mental Health in All Policies.
- January 2016, France (Paris): the Secretariat presented the Recommendation at the OECD Labour Policy Ministerial and Policy Forum on the Future of Work, and the Recommendation was welcomed and recognised in the Ministerial Statement.
- April 2016, United States (Washington): the Secretariat presented the Recommendation at Out of the Shadows: Making Mental Health a Global Development Priority, a ministerial event organised by the World Health Organization and the World Bank Group. The World Bank Group committed to using the Recommendation "to hold countries accountable in their commitment to developing more integrated, cross-sectoral mental health policy approaches."
- October 2016, Russian Federation (Moscow): the Secretariat presented the Recommendation and its key principles at the International Conference on Mental Health in the Workplace.
- February 2017, Norway (Oslo): the Secretariat was invited by the Norwegian Presidency of the Nordic Council to present the findings of the Recommendation at the Nordic Mental Health Summit.
- April 2016, Netherlands (Amsterdam): the Secretariat presented the Recommendation and key messages on how to support the mental health of young people at the European Youth Conference hosted by the Dutch Presidency and organised by the Dutch National Youth Council.
- October 2018, United Kingdom (London): the Secretariat co-hosted the Global Ministerial Mental Health Summit together with the UK government and the World Health Organisation, at which the Secretariat presented the Recommendation and its latest findings on the linkages between mental health, work and productivity.
- December 2018, New Zealand: the Secretariat launches Mental Health and Work: New Zealand
- September 2019, Netherlands (Amsterdam): Inaugural Symposium of the Amsterdam Satellite of Cochrane Work.
- October 2019, Belgium (Brussels): the Secretariat presented its ongoing work on integrated mental health and work and the Recommendation at a seminar on The Future of Work and Mental Health organised by the European Alliance for Mental Health.
- November 2019, Switzerland (Geneva): the Secretariat presented the Recommendation and the OECD's ongoing work on mental health and work at a landscape forum on the development of global guidelines for mental health in the workplace at the invitation of the World Health Organisation.
- September 2020, France (Paris): the Secretariat presented the Recommendation and the key conclusions from this implementation report to the Second OECD Workshop on Mental Health Performance Benchmarking.

5. Implementation of the Recommendation

59. This chapter describes how the Recommendation has been implemented since its adoption. It includes three sections:

- Section 1 looks at changes in how Adherents perceive the strategic importance of integration of mental health policy by examining their mental health plans and strategies. This section does not look at services to support individuals with mental health issues at the working level, as this is the subject of discussion in Section 3.
- Section 2 looks at efforts to raise awareness of mental health issues and address stigma that is often attached to mental ill-health. This section is prepared separate to Section 3, given that awareness raising is crosscutting by nature and is a foundation for the implementation of integrated mental health, skills and work policy at the working level.
- Section 3 constitutes the bulk of this chapter, and summarises policy developments at the working level in the past five years in the four thematic areas of the Recommendation – health policy, youth policy, workplace policy, and welfare policy. This section of the report closely resembles the body of this report.

5.1. Mental health plans: placing strategic importance on integration

60. Five years on from the adoption of the Recommendation, the importance of an integrated mental health, skills and work policy is now widely accepted in most Adherents. This is most evident from the increasingly inter-sectoral and whole-of-government approaches that are outlined in national mental health plans or strategies. In the OECD Mental Health Benchmarking Policy Questionnaire, as of February 2021, 19 of 27 Respondents had stated they have national programmes, plans or strategies that are developing cross-governmental approaches to mental health governance, and this report further confirms that progress is being made in this area.

61. There are significant differences in the approach to and extent of integration of the thematic areas – health systems, youth support systems, workplace policies, and welfare and social protection systems – in national mental health plans and strategies. Most mental health plans and strategies stay within the health system but several Adherents have recently developed mental health plans specifically for children and young people. By comparison, workplace policies and social protection systems are only occasionally integrated in national mental health plans. This means that significant areas of government policy, which could make a difference to mental health, are not included. The implication is that Adherents continue to see mental health first and foremost as an issue for the health system though with an increasing focus on the youth support and education systems. In contrast, there is less emphasis on workplace policies and social protection systems in mental health plans.

62. This section is dedicated to assessing the development of national mental health plans as such plans set the foundation for a systemic shift towards more integrated thinking that spans different

governmental agencies. In the absence of an integrated approach in a national mental health plan, while there may be some good practices of integrated services that support mental health, these are likely to be isolated cases that do not reflect a general trend. It is only with a combination of integrated services at the working level and a high-level prioritisation of integrated policies (as evidenced by plans or strategies) that Adherents can fully realise integrated mental health, skills and work policies.

5.1.1. Many Adherents have recently begun to emphasise integration in their national mental health plans and strategies

63. A significant number of Adherents have included educational, employment and social protection dimensions of mental health in their national strategies or plans for the first time over the past five years. While many of these Adherents have not necessarily set clear targets or objectives, their latest plans demonstrate a clear commitment to a cross-governmental approach, which represents significant progress from previous plans that focused almost entirely on the health system.

64. An example of an Adherent that has made significant progress in its latest national mental health plan is Colombia. After first recognising the importance of addressing the socio-economic dimensions of mental health in 2013, the country put in place a new National Mental Health Policy in 2018, which calls for policies to ensure the inclusion of people with mental health issues in educational, social and workplace environments. The accompanying strategy to promote this plan, which was published in 2020, sets out clear areas of responsibility for a wide range of government ministries.

65. In Poland, the National Mental Health Protection Programme for 2017 to 2022 calls for implementation of mental health policy by a range of ministries – health, social security, family, education, labour and beyond – and includes a specific qualitative objective of improving employment support provided to jobseekers with mental health conditions. The national mental health plans and strategies of Czech Republic also show an increasing emphasis on the employment and social protection dimension of mental health policy, with its most recent plan in 2020 including a goal to reduce unemployment among individuals experiencing severe mental health conditions by 5% by 2024.

66. These recent examples show that regardless of where an Adherent is at in its mental health reform process, they can put in place national plans and strategies on mental health that emphasise the importance of educational, employment and social protection dimensions of mental health. For Adherents that fall in this category, the challenge remains to translate these strategies into action, and furthermore, to develop clear measures and objectives to assess improvements in the integration of the education, employment and social protection dimensions of mental health policy.

5.1.2. Youth as a target group in national and sub-national mental health strategies

67. The development of new mental health plans specifically for children and youth clearly indicates the importance given to this demographic age group among Adherents. In the OECD Mental Health Benchmarking Policy Questionnaire, 17 out of 27 Respondents reported having specific national or sub-national mental health strategies for children and/or young people (OECD, 2020[14]). This represents a stark change over the past twenty years, as no country had such a plan at the beginning of this century (Shatkin and Belfer, 2004[15]). While approaches differ from Adherent to Adherent, many noteworthy strategies and plans on child and youth mental health have been put into place recently that may offer insights into other Adherents seeking to prioritise this policy area.

68. In both Ireland and the United Kingdom, for example, taskforces have recently delivered reports on child and youth mental health that have become de facto national mental health plans. In England (United Kingdom), the taskforce prepared the publication, Future in Mind in 2015, which set out clear recommendations for the government to pursue to address shortcomings on child and youth mental health. The key themes, which include early intervention, low-threshold services and developing the workforce,

are all closely aligned with the Recommendation. Future in Mind has since evolved into a national initiative of the Ministry of Health and NHS England. A taskforce was also recently commissioned in Scotland (United Kingdom), and the recommendations from the taskforce were published in 2019. Similarly, in Ireland, the recommendations from the taskforce report in 2017 recognised the importance of strengthening mental health services in both schools and higher education institutions, including the transition from school to university, which the Recommendation recognises as a key area for improvements in mental health policy.

69. While France and New Zealand have taken a different approach by placing mental health within the broader framework of wellbeing, they have also clearly prioritised the mental health of children and young people. In France, the President requested the development of a *Plan d'action en faveur du bien-être et de la santé des jeunes* (or Action plan for youth wellbeing and health). The action plan, launched in 2016, includes concrete actions to promote earlier identification and timelier treatment for individuals with mental health conditions through strengthening psychological support available in higher education institutions, as called for by the Recommendation. New Zealand launched its first-ever child and youth wellbeing strategy in 2019 led by the Department of the Prime Minister and Cabinet, which identifies improving support for children and young people to promote mental wellbeing as one of three priority areas. It is worth noting that in both Adherents, the initiative did not come from the health system, but from the President and the Department of the Prime Minister and Cabinet, indicating that the prioritisation of child and youth mental health is increasingly coming from central government figures.

70. In Canada, where mental health strategy is largely set by provinces and territories, innovative child and youth mental health plans have also recently been developed. The Framework for the Delivery of Integrated Services for Children in New Brunswick 2015, for example, sets out a vision for more integrated mental health services and guiding principles on implementing such practices, which closely resembles the Recommendation. In some other Adherents, child and youth mental health plans are currently in development. For example, in Australia, in August 2019, the government announced it would develop its first-ever National Children's Mental Health Strategy. The National Mental Health Commission will be responsible for delivering the strategy.

5.1.3. Few Adherents are fully integrating employment and social protection dimensions in national mental health plans

71. While some Adherents have national mental health plans that take into account the employment and social protection dimensions of mental health policy, most of these plans are not clear on how progress can be measured. While plans, may, for example stress the importance of supporting the employment of individuals with mental health conditions, such references are often fleeting or merely principles as opposed to measurable targets.

72. England (United Kingdom) stands out as an Adherent that has made significant progress over the past five years in fully integrating the employment and social protection dimensions of mental health policies in their strategies. The approach is based primarily on targets to expand access to integrated services. For example, the government accepted all the recommendations from the 2016 Five Year Forward View for Mental Health by the Independent Mental Health Taskforce to the NHS in England, which explicitly called for better integration of employment and the social protection system in mental health policy. One of the targets is to increase the number of people with mental health conditions supported in finding or staying in work by 29 000 each year through to 2020/2021 by expanding both the Increasing Access to Psychological Therapies initiative (IAPT) and Individualised Placement and Support (IPS) programmes (2016[16]).

5.1.4. Structural challenges remain to translate national mental health plans into practice

73. Despite the widespread rhetoric and intention for a more integrated mental health, skills and work policy in national mental health plans, successful implementation of such integration remains the exception, not the norm. This is the running theme throughout this report, which is discussed in more detail in the four thematic areas in Section 5.3. This partly reflects structural barriers that make working-level collaboration between multiple ministries, agencies and departments within governments costly or difficult to implement. This is a particularly significant obstacle when addressing mental ill-health, as the topic does not easily fall into the existing organisational structure of governments and civil society.

74. The Policy Questionnaire responses indicate that Respondents are aware of these structural challenges and the difficulties they impose on implementing integrated mental health, skills and work policy. For example, Ireland organised three pathfinder projects to experiment and help develop new models for more effective whole-of-government work as part of its Civil Service Renewal Plan. One of the pathfinder projects was specifically on youth mental health policy, the findings of which were released in 2017. Ireland is currently in the process of establishing a Youth Mental Health Pathfinder Team to put these findings into practice.

75. Similar measures have been taken in Sweden, where in 2015, the government commissioned a national coordinator to look into the state of mental health policy and make structural recommendations to allow for better coordination of mental health policy at various levels, including for example, between government ministries and agencies, municipalities and the health sector. On the basis of the findings of the inquiry of the national coordinator (Swedish Ministry of Health and Social Affairs, 2019[17]), 24 government agencies have been asked to jointly develop a new strategy for mental health and suicide prevention policy, which will be presented in 2023.

76. Meanwhile, in the United Kingdom, a Work and Health Unit (WHU) was set up in 2015 as a joint unit of the Department for Work and Pensions and Department of Health and Social Care, with the aim of taking a whole-of-systems approach to health, including specific measures related to mental health. To address the siloes that limit integrated approaches to health and work policies, the WHU prepared a report in 2019 setting out proposals on how the government and employers can better support workers managing health conditions, including mental health issues, at work (HM Government, 2019[18]). The proposals were then made available online in a public consultation, and the findings from this will be released shortly.

77. There also remains a shortage of investment seen in mental health policies across Adherents despite the increasing political will to address mental health issues. While methodological challenges make comparison across countries difficult, based on responses to the OECD Mental Health Benchmarking Policy Questionnaire, among Adherents for which data is available, mental health spending as a proportion of total health spending largely remained unchanged between 2010 and 2018 (OECD, 2020[19]).[7]

78. Given the continued shortage of investment in mental health and barriers to integrating mental health policies, financial incentives can play a key role in encouraging stakeholders to develop more coherent and integrated mental health services. As a starting point to create such financial incentives, it is essential that budgets are also allocated to mental health in ministries other than the Ministry of Health. Responses to the OECD Mental Health Benchmarking Policy Questionnaire indicate that only few countries have such dedicated mental health budgets for ministries other than the Ministry of Health and that many Respondents had difficulty in identifying whether a dedicated mental health budget existed (OECD, 2020[14]). This indicates that this is an area where Adherents can make significant progress over the coming years.

---

[7] This includes data from Australia, Canada, Greece, Ireland, Japan, Norway and Poland. Only in Greece has mental health spending as a percentage of total health spending substantially increased.

79. In this context, New Zealand has adopted a novel approach to creating financial incentives for more integrated mental health services through the 2019 Wellbeing Budget. Instead of basing the budget on initiatives developed by ministries and agencies, the budget is based on priority areas to promote wellbeing that are first identified in Cabinet (New Zealand Treasury, 2019[13]). This has resulted in dedicated and record levels of funding being allocated to Taking Mental Health Seriously. While mental health may not have been the top priority for any specific agency or ministry, it was identified as one of five key priority areas where there are the greatest opportunities to improve the wellbeing and lives of New Zealanders.

5.2. Raising awareness and addressing stigma: campaigns remain prevalent across Adherents

80. Much like sub-national plans and strategies, mental health awareness among the public is a key requirement for developing fully integrated mental health, skills and work policy. *Fit Mind, Fit Job* noted how discrimination against those living with mental health conditions remains widespread, and that this creates barriers to participation in schools and in work. This section is dedicated to awareness-raising, since as the Recommendation outlines, the importance of awareness and self-awareness cuts across all four thematic areas – health systems, youth support systems, workplace policies and social protection systems.

81. More specifically, awareness and understanding of mental health among the general public is crucial, as the experience of individuals with mental health conditions are shaped heavily by the attitudes of those around them – whether that be family, fellow students or co-workers. Awareness-raising is thus key to addressing recommendations specifically on awareness (1a), improving the overall school and preschool climate as called for by recommendation (2a), and to actively promote workplace mental health as called for by recommendation (3b).

82. Awareness-raising also goes hand-in-hand with increasing the mental health competence of front-line actors as called for in recommendations (1d) and (4c). Awareness is particularly important for those who come into regular contact with individuals with mental health conditions, whether teachers, caseworkers or line managers, as without awareness, there is no foundation on which to build competence. This is why recommendation (2d) draws the clear link between improving awareness and increasing the ability of education professionals and families to identify possible signs and symptoms of mental distress.

83. In the absence of public awareness, all other initiatives to promote mental health and support individuals with mental health conditions are significantly weaker. For example, in the absence of self-awareness, working individuals are unlikely to seek support as they may dismiss mental health issues or distress they experience. Even if they are aware of the need to seek help, they are unlikely to do so if they sense that their co-workers will ostracise them, or if they sense that any colleague or manager they seek help from would be dismissive of their need for treatment or support. In such an environment, workplace programmes that offer support for individuals with symptoms of mental distress may even result in misleading findings where no one seeks mental health support even in a workplace that is not conducive to positive mental health. The same analogy applies to schools and higher education institutions, as well as in social protection systems and welfare services.

84. Over the past five years, awareness-raising campaigns have been run across many Adherents at different stages in their mental health policy. This is reflected in the responses to the OECD Mental Health Benchmarking Policy Questionnaire, in which as of February 2021, 23 out of 27 Respondents stated that they had at least one national or regional anti-stigma or mental health literacy programme (OECD, 2020[14]). In some Adherents, where there is greater stigma surrounding mental health, awareness-raising is emerging as a key priority in the development of an integrated mental health, skills and work policy. In others, awareness-raising campaigns have existed for decades, and in many cases, successfully started

a conversation surrounding mental health that continues today. In both of these broad categories, Adherents are taking innovative steps to raise awareness further among the general public and front-line actors.

5.2.1. Some Adherents are placing new emphasis on raising awareness

85. A few Adherents appear to have significantly expanded their awareness-raising campaigns over the past five years. For many of these countries, awareness-raising goes hand-in-hand with a policy focus on shifting away from institutionalised care and towards supporting community care. This is because the fear and misconceptions about the "mentally ill" is a key obstacle to ensuring the acceptance of individuals experiencing mental health issues in the community.

86. One of the clearest examples to address the negative links between stigma and institutionalised care is in Latvia, where the *Cilvēks, nevis diagnose* (Human Not Diagnosis) anti-stigma campaign launched in 2018 aims to make people aware of why deinstitutionalisation is necessary and encourages the public to support a shift towards more community-based social services. The campaign has been run by the Ministry of Welfare, and tells the experiences and stories of individuals experiencing mental health conditions to promote empathy and a better understanding of their capacities, rather than limitations. In doing so, the campaign also has the explicit aim of making people aware of why deinstitutionalisation is necessary and encouraging the public to support a shift towards more community-based social services. The awareness campaign was combined with efforts to develop community-based services for individuals with mental health conditions. According to the policy questionnaire response, 20% of Latvia's population had heard about the campaign by the end.

87. Meanwhile, in Estonia, there are two campaigns notable for their emphasis on self-awareness and on encouraging people with mental health conditions to open up. "I'm all right", launched by the Ministry of Social Affairs in 2017, targeted young people aged 13-16 through a video campaign and encouraged them to seek help and talk about their concerns. Meanwhile, in 2018, *Peaasjad* (Head Matters), an Estonian non-governmental organisation ran a campaign to raise self-awareness of depression with support from the Ministry of Social Affairs. The campaign encouraged individuals concerned by their mental health to complete an anonymous online screening test using a ten-item depression scale (DEPS). As of March 2018, as many as 20 000 individuals had taken the test, with uptake of the online test conducted in over 30 organisations. Other Adherents including the Czech Republic and Poland have also recently put in place national-level awareness raising campaigns. The example of mental health awareness campaigns in the Czech Republic are discussed in Box 5.1.

88. A running theme in these awareness campaigns is the funding from the European Social Fund and the European Economic Area and Norway Grants, which indicates that these Adherents are closely aligned with the increased focus on mental health seen in Europe as a whole. At the same time, this does not mean that all Adherents in comparable situations in Europe have national mental health awareness campaigns. Greece, for example, has not had a national awareness campaign since its last initiative ended in 2013. Meanwhile, in Slovenia, while the National Mental Health Plan for 2018-2028 stresses the importance of addressing stigma, the existing campaigns remain locally based, although there are plans to put in a place a national anti-stigma campaign.

5.2.2. Many Adherents are continuing their established awareness activities and campaigns

89. In a number of Adherents, awareness-raising and anti-stigma programmes have existed for decades, and these activities are being continued, or in some cases even strengthened. Although Adherents take varying approaches, these campaigns tend to be largely delivered by non-governmental organisations, reflecting their particular importance in awareness-raising activities. These programmes

often run throughout the year but are scaled up around relevant awareness days such as World Suicide Prevention Day, Mental Health Awareness Week and World Mental Health Day.

90. In New Zealand, for example, the main national anti-stigma programme continues to be Like Minds, Like Mine, a programme established in 1997 and funded by the Ministry of Health to reduce discrimination against and encourage inclusion of those living with mental health conditions. Like Minds, Like Mine launched its most recent campaign, "Just Like, Just Listen", in 2018, which promotes individuals to ask and listen to the experiences of those with mental health conditions, rather than assuming their needs or capabilities. While the strategic responsibility for the programme lies with the Ministry of Health, the communications for the programme are being led by the Mental Health Foundation of New Zealand, a prominent non-governmental organisation. Another example of a well-known government-funded mental health campaign is Opening Minds in Canada, which was established in 2009 by the Mental Health Commission of Canada, which is funded by Health Canada and operates at an arm's length from government.

91. In France, Psycom, which is financed by Public Health France, the Ministry of Health, and regional health agencies, provides a hub for information on mental health. The public information body provides to authorities information on mental health, tools to fight against stigmatisation and discrimination of individuals experiencing mental health issues, as well as training. Although Psycom was established as far back as 1992, it was only in 2015 that its mission was expanded from the Paris region to the national level. One notable recent activity by Psycom has been an exercise to map the growing number of information sources available on mental health across the country at the request of Public Health France. The exercise culminated in a report published in 2020, which found that while information on mental health may be increasingly available, knowing what information is relevant and of high-quality is becoming increasingly difficult (Psycom, 2020[20]). This shows a key challenge that countries may face as awareness-raising activities proliferate and sources of information become disperse and wide-ranging.

92. Independent activities of non-governmental organisations can also play a prominent role and have significant outreach. For example, in England (United Kingdom), Time to Change has been run since 2007 by Rethink Mental Illness in partnership with Mind, while the Mental Health Foundation has run a large scale campaign on mental health since it set up the Mental Health Action Week in 2001, which has since become the Mental Health Awareness Week. Other prominent charities such as the Mental Health Foundation and the Royal Foundation of the Duke and Duchess of Cambridge are also running their own campaigns. Other Adherents such as the United States and Australia also have significant charities and non-governmental organisations that raise awareness of mental health issues and have an international reach.

93. Among initiatives by non-governmental organisations since the adoption of the Recommendation, Heads Together founded in 2016 by the Royal Foundation of The Duke and Duchess of Cambridge is a notable recent and ongoing initiative. Spearheaded by the Duke and Duchess of Cambridge, the initiative seeks to "change the conversation on mental health" working closely with partner organisations. As part of this initiative, the Heads Up campaign was launched in 2019 together with the Football Association (FA). The campaign was driven by leading figures from football talking about mental health and centred around the dedication of the 2020 FA Cup to generating conversation on mental health.

94. Furthermore, since 2012, there has been a Global Anti-Stigma Alliance, which brings together well-established campaigns to promote mutual learning. The most recent meeting in 2017 was hosted by the ONE OF US organisation with partial funding from the Danish Health Authority. Representatives from more than 10 national anti-stigma programmes attended the meeting, and shared evidence and lessons learnt from their respective programmes. It is also worth noting that Time to Change launched a global programme to raise awareness abroad in 2018, and is regularly cited as a model followed by non-governmental organisations and governments that have recently implemented national awareness campaigns such as in the Czech Republic.

5.2.3. Awareness-raising efforts increasingly go beyond the health system

95. Across Adherents, awareness-raising campaigns are also increasingly targeting youth and the workplace, and stressing that addressing the stigmatisation of mental health requires the involvement of all actors in society. In most national campaigns, children and young people are explicitly stated as a target and there are also networks and non-governmental organisations dedicated to raising awareness of mental health among younger audiences. These activities combined with the inclusion of mental health in school curricula promote greater awareness and literacy of mental health issues as discussed in Section 5.3.2.

96. While workplaces are not covered as frequently by awareness raising programmes, there are a number of noteworthy recent initiatives that seek to raise understanding of the close interlinkages between the working environment and mental health. This is a promising trend. For example, the Netherlands has made raising awareness of work-related stress a priority of its occupational health and safety policy. As part of this, a "Week for Work-related Stress" has been organised every November since 2014, with activities organised on each day of the week on different themes. In 2019, "Masterplan Monday" was dedicated to both employers and employees developing plans and conversation techniques together to reduce work-related stress and improve wellbeing at work.

97. Meanwhile, in the United Kingdom, *See Me*, the Scottish programme to tackle mental health stigma and discrimination, implemented an evidence-based and highly effective anti-stigma campaign aimed at the workplace. *See Me* commissioned a poll and found that for both employers and employees, there was fear surrounding mental health as a topic in the workplace, with 48% of individuals responding that they did not tell their employers about mental health problems for fear of losing their job. Based on these findings, *See Me* launched their *The Power of Okay* campaign in November 2015, which encouraged individuals to ask the simple question, "Are you okay?" and put the audience in the shoes of the challenges related to mental health that both employers and employees might face in their day-to-day working lives.

98. Most recently, in October 2020, in Germany, a Mental Health Offensive was launched as an inter-ministerial effort to encourage more open discussion of mental health issues in all areas of society, including in schools and workplaces. The initiative also seeks to increase understanding among individuals experiencing mental health conditions on how they can access support, and promotes collaboration across sectors to ensure mental health support is more readily available in all areas of society (Initiative Neue Qualität der Arbeit, 2020[21]). What is notable about this initiative is its explicit focus on the interlinkages of mental health with broader society, as evident from the involvement of the Federal Ministry of Labour and Social Affairs, the Federal Ministry of Health, and the Federal Ministry for Family Affairs, Senior Citizens, Women and Youth.

Box 5.1. Raising awareness of mental health in the Czech Republic

In 2017 to 2018, the National Institute of Mental Health (NUDZ) of the Czech Republic launched *Na Rovinu* as a national campaign to address stigma towards individuals with mental health conditions, which is particularly high in the Czech Republic. For example, only 25% of those surveyed in 2015 said that they would not mind working with someone with a mental illness.

The concept behind *Na Rovinu* is to encourage all actors in society to speak plainly or frankly about mental health – including individuals experiencing mental health conditions – and to deepen public understanding of mental health issues. The key target groups identified in the project are individuals with mental health conditions and their relatives, as well as among paramedics, social workers and the public administration, as these are groups that regularly engage with individuals with mental health conditions.

The *Na Rovinu* website acts as a hub with information on mental health. This includes, for example, tips on how to communicate in a non-stigmatising manner about mental health, the rights of individuals with mental health conditions, and facts and myths surrounding mental health. The personal stories of individuals with lived experiences of mental health conditions are also shared with consent both through the website and social media in an attempt to bring mental health in to day-to-day discussions. *Na Rovinu* also organises events to educate and inform the public on mental health, including on mental health considerations amidst the COVID-19 crisis, as well as aligning campaigns with international movements such as World Mental Health Day.

The *Na Rovinu* project is complemented by mental health awareness initiatives run by non-governmental organisations. This includes *Můj Mindset* (My Mindset), which was started in 2016 and ran a video campaign to tackle prejudice with support from government agencies and Norway Grants, and *Nevypusť duši* (Don't Drain the Soul), a non-profit organisation founded in 2015 which runs workshops for high school students in the Czech Republic, drawing on examples of successful awareness-raising campaigns in the United Kingdom.

Looking ahead, efforts to raise awareness of and address stigma associated with mental health conditions will remain a priority for the Czech government. In the National Action Plan for Mental Health 2020-2030, one of the key objectives for the Ministry of Health is the continued implementation of a nationwide mental health anti-stigma campaign. Non-governmental organisations were consulted in the process of developing this action plan.

Sources:
NA ROVINU (2020), NA ROVINU, www.narovinu.net
STOP STIGMATIZACI! KAŽDÝ ČLOVĚK SI ZASLOUŽÍ POROZUMĚNÍ (2020), Můj Mindset [My Mindset], www.mujmindset.cz
Nevypusť duši: Nebojíme se mluvit o duševním zdraví (2020), Nevypusť duši [Don't Drain the Soul], www.nevypustdusi.cz

5.3. Integration of mental health policy at the working level across the four thematic areas

5.3.1. Health care systems: increasing emphasis on mental health but the shift towards integration with skills and work interventions remains slow

99. Health care systems often face a double challenge of under-investment in mental health care and structural barriers to integrating such care with social and employment support. However, there has been

progress in several Adherents on both challenges, in line with the direction of the Recommendation. More investment in mental health care is increasingly widespread, and many Adherents have set initiatives that improve the mental health competence of all health care providers. This is a critical first step, but one that has to be followed by more intentional policy and structural changes to more closely integrate mental health care with social, educational and employment supports and interventions. The importance of supporting people to stay in or return to work or school also needs to be given greater prominence and consideration in the mental health care system.

Box 5.2. Relevant extracts of the Recommendation on health care systems

I.RECOMMENDS that Adherents seek to improve their mental health care systems in order to promote mental wellbeing, prevent mental health conditions, and provide appropriate and timely services which recognise the benefits of meaningful work for people living with mental health conditions. To this effect, Adherents should, as appropriate:

a) foster mental wellbeing and improve awareness and self-awareness of mental health conditions by encouraging activities that promote good mental health as well as help-seeking behaviour when mental illness occurs and by building effective strategies to address stigma in consultation with a range of government and non-government stakeholders;

b) promote timely access to effective treatment of mental health conditions, including mild-to-moderate mental illnesses, in both community mental health and primary care settings and through co-location of health professionals to facilitate the referral to specialist mental health care, while ensuring the involvement of people living with mental health conditions in decisions about the appropriate care and treatment plan;

c) strengthen the employment focus of the mental health care system, particularly by carrying out awareness-raising activities to emphasise the positive contribution quality work can make to recovery, by introducing employment outcomes in the health system's quality and outcomes frameworks, and by fostering a better coordination with publicly- and privately-provided employment services;

d) expand the competence of those working in the primary care sector, including general practitioners, family doctors and occupational health specialists, to identify and treat mental health conditions through better mental health training for health professionals, the incorporation of mental health specialists in primary care settings, and clear practices of referral to, and consultation with, specialists;

e) encourage general practitioners and other mental health specialists to address work (or school) and sickness absence issues including by using evidence-based treatment guidelines which support return to work (or return to school) where possible and by ensuring that health professionals have the resources to devote sufficient time to address work issues.

Mental health conditions are overlooked too often in the health system

100. *Sick on the Job? Myths and Realities about Mental Health and Work* showed that in in 2010, only around 50% of people with severe and 30% of those with mild-to-moderate mental health conditions received treatment (OECD, 2012[1]). While progress has been made to increase access to treatment, many people experiencing mental ill-health still do not receive any treatment, and even for those who do, treatment may not be timely or targeted. Recommendation (1b) therefore calls for the promotion of timely and effective treatment of mental health conditions including mild-to-moderate cases through community mental health care and primary care, but also through referrals to specialist mental health care. In addition, recommendation (1d) calls for increased mental health competence of front-line actors in the health care system – especially general practitioners – to ensure adequate treatment and well-targeted referrals.

101. As outlined in *Fit Mind, Fit Job,* health care systems in OECD countries also often fail to take into account the benefits of meaningful work and schooling for people experiencing mental health conditions and the subsequent crucial role that health practitioners have in supporting people to return to (or remain in) work or school. This is why the Recommendation calls for a strengthening of the employment focus of the mental health care system (1c) and strengthening of treatment guidelines for health professionals on how to support return-to-work and return-to-school (1e).

Most Adherents recognise that health systems need to focus more on mental health

102. While it is beyond the scope of this report to cover all areas of mental health services, the policy questionnaire responses indicate that most Respondents recognise the need to strengthen mental health services in the health system including for people experiencing mild-to-moderate mental health conditions. This perspective is captured in the *Achieving Better Access to Mental Health Services by 2020* vision for mental health services in England (United Kingdom) released in the autumn of 2014, which states that: "for decades the health and care system in England has been stacked against mental health services and against the people who use them."

103. Based on the questionnaire responses, in a number of Respondents, increasing the capacity and scope of mental health services appears a key priority. One of the ways that Adherents have done this is by increasing the size of the workforce in the mental health system. New Zealand, for example, is currently implementing its *Mental Health and Addiction Workforce Action Plan for 2017-2021*, while the United Kingdom's mental health workforce plan published in 2017 set out a target to employ 19 000 additional members of staff in the mental health workforce by 2020 in the National Health Service.

104. The questionnaire responses also confirm that a number of Respondents continue to focus on shifting from hospital- to community-based mental health services. In these Adherents, the focus of health system reform seems to be on increasing availability and capacity of community-oriented mental health services. For example, in Poland, starting in July 2018, the government has been piloting 27 mental health centres that together can provide support to around three million people. Meanwhile, in Hungary, six health promotion centres were launched in May 2016 with the aim of identifying key mental health issues in specific districts, and collecting and evaluating good practice to prevent and treat mental health conditions. Other Respondents that mentioned measures to strengthen community-based mental health care included, but are not limited to, Greece and the Czech Republic.

Digital technologies are playing an increasingly important role

105. *Fit Mind, Fit Job* noted that OECD countries could consider exploring the use of electronic cognitive-behavioural therapy (eCBT) for individuals with mild-to-moderate mental health conditions, and especially work-focused eCBT, given that it is less costly than face-to-face treatment and has potential for significant outreach, which may allow for more timely intervention and support. Since the adoption of the Recommendation, there has been a rapid expansion of a broader range of technology-enabled mental

health services, much of which has been driven by increased investment from the private sector. A recent study has found that over the past six years, global funding into mental health technology has increased almost five-fold from around USD 156 million in 2014 to USD 750 million in 2019 (Octopus Group, 2020[22]).[8]

106. In particular, app-based tools that provide low-threshold support and offer programmes designed to strengthen self-management, mindfulness and coping skills have boomed. One of the challenges with such apps is to ensure they deliver effective support for individuals experiencing mental distress (Anthes, 2016[23]). A promising initiative to address this potential issue has been the development of a National Health Services Apps Library in England (United Kingdom). Founded in 2017, this library offers a growing list of apps – including many designed to promote better mental health – that have been assessed as being "clinically safe and secure to use" (NHS, 2020[24]).

107. Investing in a range of digital health technologies including telehealth services, online programmes and app-based support seems especially timely given the ongoing COVID-19 pandemic, which has restricted face-to-face treatment, and resulted in increased reliance on remote treatment and support. Most Adherents acted quickly to scale up and introduce telehealth services dedicated to providing mental health support. The challenge is now to transform these emergency measures into well-integrated and established digital mental health services. A notable example of an integrated approach to using digital tools to increase access to mental health support is Finland's *Mental Health Hub*, which is described in Box 5.3. Building a future-focused and innovative mental health sector as called for by the OECD Mental Health Performance Framework requires Adherents to take initiative to leverage the possibilities of digital technologies to provide more timely access to mental health support.

[8] GBP 120 million in 2014 to GBP 580 million in 2019

Box 5.3. Finland's Mental Health Hub

In 2009, the Helsinki University Central Hospital (HUS) developed an eService for individuals with mental health conditions called *Mielenterveystalosta* [*Mental Health Hub*] with funding from the government. The motive was to address the fragmented nature of mental health services and to provide better support for individuals in rural areas, which is especially pertinent in a country such as Finland with its low population density and ageing population. *Mental Health Hub* aims to provide more patients with more timely and better quality access to mental health support. At first, the initiative focused on providing services for the local community, but was expanded into a nationwide online service in 2015.

The *Mental Health Hub* is a free one-stop hub offering a variety of mental health services. Self-help tools are easily accessible on the hub and help to promote mental health literacy for individuals looking for information, and since 2014, individualised therapy programmes have also been available. For an individual with a referral, free consultations and professional-guided eCBT are also available, as the government covers medical fees. The range of therapies has been expanded significantly in recent years, with online therapy now available for depression, alcohol use, anxiety, panic disorders, bipolar disorder and eating disorders.

One of the innovative features of the *Mental Health Hub* is the symptom navigator, which allows users to be directed to the most appropriate form of support depending on the severity and nature of mental distress. The *Mental Health Hub* even includes a portal dedicated to health and social care professionals so that they can receive training in mental health support and access relevant materials and tools designed by HUS. Materials are designed for not only mental health specialists, but also health care professionals in primary care, nursing and third-sector organisations such as charities. The *Hub* has seen a rapid increase in use among the general population. In the autumn of 2015, there were around 53 000 unique monthly visitors which had risen to in excess of 200 000 unique monthly users by the spring of 2019.

Although the *Hub* cannot replace all face-to-face services, it holds great potential to transform the traditional doctor-centred health system. According to HUS, virtual visits cost around half that of in-person visits and in the case of mental health treatment, and psychotherapists can treat three patients in the time it used to take to see one, which has resulted in the near elimination of waiting lists. It is worth noting that the *Hub* is only possible because Finland has invested in health data for decades. HUS has used an electronic patient information system for over 25 years, while the *My Kanta* patient portal allows all individuals with a Finnish personal identity code to access and interact with their health records.

One of the advantages of the *Mental Health Hub* is its scalability of the technology. This has allowed HUS to expand the *Hub* into a national virtual hospital called *Health Village* that goes far beyond mental health services. As of 2020, *Health Village* has 32 specialist hubs, 115 digital care pathways and 5 virtual knowledge centres with over 540 000 users per month. The expansion of the *Health Village* was funded by the Finnish Ministry of Social Affairs and Health, and made possible through collaboration with technology key partners such as Innofactor and Microsoft.

Sources: Digital Health Village (2020), Helsinki University Hospital, *www.digitalhealthvillage.com/*; What can the UK learn from Finland's approach to mental health? (2017), The Guardian, *www.theguardian.com/healthcare-network/2017/apr/05/what-uk-learn-finland-approach-mental-health-nhs*; Virtual Hospital improves patients' healthcare access, dramatically cuts costs (2017), Microsoft, *www.customers.microsoft.com/en-us/story/helsinki-university-hospital-health-office-365*

Increasing the mental health competence of health professionals

108. Closely tied to increasing the capacity of the mental health system, is the need to ensure that health professionals – and in particular, general practitioners (GPs) – have sufficient knowledge and training to ensure they have the competence and confidence to not only identify mental health conditions, but also to provide treatment and/or refer the individual to a mental health specialist where appropriate. In many cases, front-line actors in the health system already receive initial training in mental health, but may nonetheless benefit from receiving further training. Many Adherents have implemented policies to strengthen the mental health competence of health professionals over the past five years.

109. In the Czech Republic, for example, as part of reform to the primary care sector, GPs are currently being trained to increase their competence across all areas including mental health, and to support GPs in speedy and effective diagnosis of mental health conditions, the government has stated its intention to develop best practices and guidelines for diagnosing mental health conditions. Another example is Latvia, where as part of the new *Mental Health Plan* approved in 2019, GPs and nurses are being trained in mental health through educational programmes.

110. Going further, training for key health professionals can take an integrated mental health and employment approach. In Australia, meanwhile, there is a promising project currently underway by researchers from Monash University to increase the understanding of the interlinked nature of mental health and work. The project aims to develop and trial guidelines for GPs to improve their ability to support individuals who face issues at work which may be adversely affecting their mental health. The project will also include an evaluation on the feasibility of scaling up nationwide after the trial period.

111. In a number of Adherents, the World Health Organisation's Mental Health Gap Action Programme (mhGAP) has helped to initiate training of primary health care workers in mental health. The programme has played a particularly prominent role in the Latin America and Caribbean region in recent years, with mhGAP having been implemented in all Adherents in this region (Chile, Colombia, and Mexico) as well as in Costa Rica. In Colombia, for example, with support from the Pan American Health Organisation (PAHO), close to 2000 non-specialised professionals in the health sector had already been trained through the mhGAP as of October 2019, while Costa Rica is currently implementing a proposal developed with PAHO to train primary health care workers in mental health.

Measures are being taken to reduce waiting times for mental health care

112. There is also a growing recognition among Respondents of the need to provide more timely access to specialist care in the health system in line with recommendation (1b). *Fit Mind, Fit Job* noted that individuals often face long waits – even in OECD countries with highly advanced health systems – to receive appropriate mental health care. At least ten Adherents report having a waiting times target or guarantee in at least one area of mental health care, and a few Adherents have separate targets specifically for children and adolescents (OECD, 2020[25]).[9] In a number of these Adherents (Finland, Norway and Denmark), a growing proportion of people are being assessed or treated within maximum waiting time targets in recent years.

113. The United Kingdom is an example of an Adherent that recently established its first waiting time standards for mental health care. Since 2016, the National Health Service in England has had a target to ensure treatment within six weeks for 75% of people referred to the *Improving Access to Psychological Therapies* programme, with 95% to be treated within 18 weeks as part of the *Improving access to mental health services by 2020* commitments. A number of other Adherents are currently developing indicators to assess waiting times. In Canada, for example, since 2018, the Canadian Institute for Health Information

[9] These Adherents are Denmark, Finland, Ireland, Lithuania, Netherlands, New Zealand, Norway, Spain (specific regions), Sweden and the United Kingdom

has been working with federal, provincial and territorial health ministers to develop indicators to measure access to mental health and addictions services. One of the set of six indicators relates directly to waiting times for mental health care services.

114. Adherents primarily consider long waiting times for mental health care to be an issue with the supply of mental health services. Nonetheless, while less common, there are a few examples of specific waiting time policies that aim to incentivise faster provision of treatment. One example is in Denmark, which expanded its "free choice of hospital" to include treatment for mental ill-health in addition to physical illness. This means that since 2015, Danish citizens can choose to access a limited range of private hospitals in Denmark as well as hospitals abroad to receive mental health care if the hospital to which they are referred is unable to fulfil the waiting time guarantee of 30 days. This creates stronger financial incentives for the health system to ensure timely access to treatment for mental health conditions. The performance of regions is monitored and data made publicly available, with the 2018 update on the National Goals suggesting a promising trend of declining waiting times for both adult and child psychiatric care across all regions in Denmark in the period 2012-2017. In 2018, 95% of all Danish patients were seen by a psychiatrist or assessed for mental health within the 30-day waiting-time target.

Initiatives from the health system to integrate mental health policy remain limited

115. Despite the clear emphasis on developing mental health systems integrated with social, educational and employment supports and interventions in many Respondents, the questionnaire responses suggest that many of the Respondents still do little in practice to integrate the employment and educational orientations of mental health within the health system itself. There are some examples of progress on this front, but the shift is relatively gradual and the implementation of integrated mental health, skills and work policy remains slow.

116. One of the most notable initiatives of integrating employment within the mental health systems is the *Improving Access to Psychological Therapies* (IAPT) programme that has been rolled out across England (United Kingdom) by the National Health Service. First piloted in 2008 and since expanded, the programme originally aimed to expand access to therapies for individuals with mental health conditions such as anxiety and depression. In the early years of the programme, employment advisors (EAs) were also introduced to work alongside therapists to provide practical advice and support to help people to remain in work or enter the workplace (OECD, 2015[2]). While a target of one employment advisor for every eight IAPT therapists was set (1:8 ratio), in reality, in some services there was only 1 employment advisor for as many as every 50 IAPT therapists.

117. To address the lack of EAs in IAPT, starting in 2017, the Work and Health Unit[10] has been investing £39 million on recruiting EAs to provide more integrated mental health and employment support that supports people to remain in, return to or find work and to meet the 1:8 target ratio (Department for Work and Pensions and Department for Health and Social Care, 2017[26]). An evaluation report based on eight case studies from the first wave of the programme found that EAs in IAPT are well-received from relevant stakeholders, namely clients, therapists and employability partners, and early outcomes appear positive with clients citing increased confidence, improvements in mental health, and progress towards return-to-work (Loveless, 2019[27]).

118. A few other Adherents have followed the example of IAPT and are implementing programme to increase access to therapies for individuals with mild to moderate anxiety and depression. Norway's *Prompt Mental Health Care* programme was launched in 12 Norwegian municipalities in 2012, but has since been expanded further. Between 2013 and 2019, 600 psychologists were recruited in Norway

[10] WHU was set up in 2015 as a joint unit of the Department for Work and Pensions and Department of Health and Social Care

through a grant scheme to work in the municipalities, and since January 2020, all municipalities have been required by law to offer occupational therapy services.

119. Meanwhile in Sweden, since January 2020, regions have been legally required to put in place rehabilitation coordinators within the health system. The core responsibilities of these coordinators will be to promote return-to-work through engagement with employers, employment agencies and public employment services, while they will also be required to support patients during their sick leave and rehabilitation process.

5.3.2. Youth support systems: a policy priority for more integrated interventions

120. Of the four thematic areas covered by the Recommendation, the most significant progress is taking place in youth support systems. Mental health is understood by Adherents to be critical for the development of youth, and policies in many cases follow the steps proposed in the Recommendation. This includes policies that target mental health directly, as well as policies supporting youth living with mental health conditions indirectly – such as support for early school leavers. There is also growing recognition of the need for early identification and timely support, as demonstrated by the increased focus on providing low-threshold and non-stigmatising mental health services that are easy to access for young people.

Box 5.4. Relevant extracts of the Recommendation on youth support systems

II.RECOMMENDS that Adherents seek to improve the educational outcomes and transitions into further and higher education and the labour market of young people living with mental health conditions. To this effect, Adherents should, as appropriate:

a) monitor and improve the overall school and preschool climate to promote social-emotional learning, mental health and wellbeing of all children and students through whole-of-school-based interventions and the prevention of mental stress, bullying and aggression at school, using effective indicators of comprehensive school health and student achievement;

b) improve the awareness among education professionals and the families of students, of mental health conditions young people may experience and the ability to identify signs, symptoms and problems and refer students for assessment and interventions appropriate to their needs, while ensuring an adequate number of professionals is available to all educational institutions with knowledge on psychological and behavioural adaptation and accommodations required in the learning environment;

c) promote timely access to co-ordinated, non-stigmatising support for children and youth living with mental health conditions or social-emotional problems by better linking primary and mental health services and reducing waiting times in the mental health care sector and by an easily accessible support structure, linked to preschools, schools, post-secondary institutions, and other youth and community services, which provides comprehensive assistance including treatment, counselling, guidance and peer support;

d) invest in the prevention of early school leaving at all ages and support for school leavers living with mental health conditions through appropriate follow-up with due regard to personal privacy of those who have dropped out from school, or are at risk of doing so, with a view to reconnect those students with the education system and the labour market;

e) provide non-stigmatising support for the transition from school to higher education and work for students living with mental health conditions (or, for the return to education for those who have dropped out) through better collaboration and better integrated approaches by schools, post-secondary institutions, employers, employment services and the mental health care sector.

Why mental health matters in education and youth support systems

121. Around half of all mental health conditions are established by age 14, and three in four by age 24 (Kessler et al., 2005[28]). This means that in many cases, symptoms and signs of mental health issues are apparent from a young age, making mental health interventions and support in childhood, adolescence and youth particularly important for timely identification of mental health issues as recognised by recommendation (1c). If mental health issues are left unattended during childhood, adolescence and youth,

symptoms and conditions may deteriorate and prevent individuals from living fulfilling and productive working lives.

122. Schools play a particularly important role in promoting the mental health of children, adolescents and young people. This is why recommendation (2a) calls on Adherents to both monitor and improve the overall school and preschool climate to promote socio-emotional learning and mental health through whole-of-school interventions. Furthermore, irregular attendance at school can often be one of the first signs of mental health issues and eventually result in early school leaving. This is why recommendation (1d) calls for investment in both measures to support students remain in school, and for timely support for early school leavers with a view towards reconnecting these students with the education system or with the labour market.

123. Moreover, childhood, adolescence and youth are periods marked by significant transitions which can place significant pressures on mental health. Over the period of around 20 to 25 years, young individuals have to adapt from being fully dependent on a caregiver to being self-sufficient contributors to society. This is why the Recommendation places particular emphasis on transitions into higher education and into the labour market and the need to ensure support for individuals with mental health issues and conditions through each of these transitions. This is reflected most notably in recommendation (2e).

Timely intervention to prevent mental ill-health is a priority in schools

124. Many Respondents have attempted to ensure more timely action by putting in place whole-of-school approaches to identify mental health conditions among students, as well as signs of below-threshold mental distress that may be at risk of developing into clinical mental health conditions. Attempts to ensure timely identification and treatment in schools typically include a combination of policies to promote mental wellbeing and to prevent risky behaviours. These approaches share in common an attempt to address the exacerbation of mental health conditions among individuals by creating environments that are conducive to good mental health and are less likely to result in individuals developing (or aggravating existing) mental health conditions, and are often used to complement one another.

125. An example of a promotion approach to mental health in schools is Ireland's *Wellbeing Policy Statement and Framework for Practice* for 2018 to 2023. The framework not only sets out the government's vision for wellbeing in schools, but also stipulates that every school in Ireland must implement a school self-evaluation process that follows the framework and looks at wellbeing in four key areas – culture and environment, curriculum, policy and planning, and relationships and partnerships. Australia also launched its *Australian Student Wellbeing Framework* in 2018, which provides schools with guidelines on promoting the wellbeing of students from the first year of school to year 12.

126. A number of Adherents have taken more of a prevention approach, focusing on how to limit and prevent high-risk behaviours that are often associated with mental ill-health such as bullying, xenophobia, alcohol and substance use, violence and truancy. For example, in the Czech Republic, there is an ongoing *National Strategy for Primary Prevention of Risky Behaviour* that will run through to 2027, while in Poland, the Ministry of Education commissioned research on effective preventative and prophylactic programmes in schools, the results of which were made available in 2018.

127. Most Adherents also report having anti-bullying programmes and strategies at the national level, and many referred to recently implemented measures and strategies to address bullying in schools in their policy questionnaire response. In Denmark, the 2016 *Action Plan for Preventing and Combating Bullying* sets out recommendations for the state, local governments and other organisations to reduce bullying in schools and recognises the importance of anti-bullying measures to promote mental health in schools. Meanwhile, in 2018, Norway established anti-bullying ombudsmen in every county to support and give advice to pupils and parents regarding school safety. A report released in 2020 found that while challenges remain in providing ombudsmen themselves with adequate support in fulfilling their mandate and with

ensuring equal access to support across region, the ombudsmen scheme has helped to create a safer environment for children in kindergarten and at school (Seland et al., 2020[29]).

128. New Zealand is also implementing national-level face-to-face assessments of the mental well-being of secondary students in an attempt to ensure early identification of possible undisclosed or undiagnosed mental health conditions. This involves rolling out the *HEEADSSS Wellness Checks* – an interview-based face-to-face assessment consisting of questions relating to home (H), education and employment, eating and exercise (E), activities (A), drugs and alcohol, depression and suicide (D), and sexual health, safety and personal strengths (S) – to Year 9 students across the country. These assessments were initially implemented as part of the *Youth Mental Health Project*, which was launched in 2012. As of 2019, these wellness checks were performed in 40% of secondary schools, and further extensions are planned.

129. These in-school early identification measures are also complemented by low-threshold and non-stigmatising mental health support services outside schools for young people in many Adherents. Examples include *Ohjaamo* one-stop guidance centres in Finland, and headspace services in Australia. By avoiding labelling individuals as sick or problematic, such services can encourage children and young people to seek support when showing first signs of mental ill-health. This can help to ensure treatment and support is made available early before individuals experience more severe mental health conditions and before they have lost connection with schools, apprenticeships or the workplace.

130. The key to both in-school and out-of-school measures is to ensure they are followed up by timely and appropriate intervention when mental distress or possible mental health conditions are identified, including where appropriate, through referrals to specialists. It is crucial that these measures are complemented by strengthened links and transitions between youth support systems and the mental health system that can help to ensure timely follow-up. In this context, England's Link Programme provides a promising example. As discussed in Box 5.5, the programme brings together education professionals from schools and mental health professionals from the health system to strengthen collaboration, with evidence from the pilot stage suggesting that the programme is strengthening the quality and timeliness of referrals from schools to the health system.

Efforts to increase competence of teachers and educators are widespread

131. Most Adherents provide some form of training on mental health to teachers, educators and other front-line education professionals who regularly engage with students, although in some Adherents, coverage of such training remains limited. The importance attributed to training teachers is also reflected by responses to the OECD Mental Health Benchmarking Policy Questionnaire. 19 out of 27 Respondents said they provided "some" or "a lot" of mental health training to teachers, with only five stating that they provided no training. This is significantly more than the 15 Respondents reporting they provide training to unemployment service counsellors or staff (OECD, 2020[14]).

132. Australia continues to take significant steps forward in this field. In November 2018, a government-funded initiative called *BeYou* was launched that provides teachers with the tools to help support the mental health of children. The service is free and available to educators, schools and early learning services in Australia, and integrates past school-based programmes such as *Kids Matter* and *Minds Matter*. As an example, *BeYou* has an Educators Handbook for both early learning services and primary and secondary schools, providing guidelines for educators on how to improve the mental well-being of students.

133. In Ireland, the National Education Psychological Service (NEPS), which supports teachers in promoting the mental health of students in primary and post-primary schools, has been expanded in recent years. In 2019, 19% of the total education budget was allocated to achieving better education and life outcomes for children with special needs, and as part of this, additional psychologists were recruited to NEPS to support students with complex educational needs (Government of Ireland, 2019[30]). NEPS also

provides specific support to school leaders and teachers in establishing student support teams in schools, including through an assigned NEPS psychologist.

134. In some Adherents, where training may not provide competence in mental health *per se*, teaching curricula increasingly emphasise the importance of socio-emotional skills that can help build mental resilience and promoting positive mental health. For example, in Mexico, there is an ongoing national programme, with over two million participants, that seeks to support socio-emotional learning in secondary public schools. After an evaluation of the programme in 2016 found there were not enough staff qualified or with the skills to teach about socio-emotional skills, directors and teachers from more than 4 200 public high schools were trained through dedicated workshops.

135. One of the most prominent tools being used to train teachers and educators in mental health is *Mental Health First Aid* (MHFA) and similar programmes that offer courses to provide lay people with evidence-based education on mental health to help them recognise, understand and respond to signs of mental ill-health. Since being first established in Australia, in 2001, there are now licensed providers of mental health first aid in 27 countries that have together trained more than three million people worldwide. While MHFA can be taken by anyone and is not limited to schools, many Adherents have set targets to expand training in schools through these programmes. For example, in the United Kingdom, in 2017, the government announced a plan to make mental health first aid training available in all secondary schools by 2020. As of March 2020, over 2 500 schools had been reached through this plan.

Box 5.5. Mental Health Services and Schools and Colleges Link Programme – England (United Kingdom)

The *Mental Health Services and Schools and Colleges Link Programme* is an initiative launched in 2015 funded by the Department of Education and supported by NHS England, which seeks to promote mutual understanding and strengthen communication between educational institutions and mental health services.

The programme centres around two one-day workshops held around six weeks apart in which education and mental health professionals come together to share "local knowledge and resources" under the leadership of local Clinical Commissioning Groups (CCGs), which are in charge of planning and commissioning mental health services in their local areas. The workshops use a specially designed framework (CASCADE) which consists of seven domains, namely:

- **C**larity on roles, remit and responsibilities of all partners involved in supporting children and young people's mental health
- **A**greed point of contact and role in schools/colleges and children and young people's mental health services
- **S**tructures to support shared planning and collaborative working
- **C**ommon approach to outcome measures for young people
- **A**bility to continue to learn and draw on best practice
- **D**evelopment of integrated working to promote rapid and better access to support
- **E**vidence-based approach to intervention

The *Link Programme* began as a pilot initiative in schools between 2015 and 2016 that involved 255 schools. An independent evaluation of the pilot found that it had significantly strengthened communication and joint working between schools and mental health services, improved the quality of referrals from schools to specialist mental health services and even raised the knowledge and awareness of mental health among school staff not directly involved in the initiative.

After the success of the pilot, the Department of Education commissioned the Anna Freud Centre for Children and Families, a non-governmental organisation, to expand and roll out the initiative across the country. Between 2017 and 2019, over 3 000 school, college and mental health professionals took part, and the programme is currently being scaled up to reach every school and college in England.

By strengthening communication and joint work between the health and school systems, the *Link Programme* is playing a dual role of improving timeliness of support for children and adolescents with mental health conditions through more effective referrals (addressing the "when" and "what" dimension) as well as raising awareness of mental health issues among educational professionals (improvement on the "who" dimension).

Source: Link Programme (2020), Anna Freud National Centre for Children and Families, https://www.annafreud.org/schools-and-colleges/research-and-practice/the-link-programme/ ; Mental Health Services and Schools Link Pilots: Evaluation report (2017), Ecorys UK, https://www.annafreud.org/media/9751/evaluation_of_the_mh_services_and_schools_link_pilots-rr.pdf

136. In comparison, the United States has taken a slightly different approach. The Substance Abuse and Mental Health Services Administration has awarded grants to state and local educational agencies as well as non-governmental organisations in recent years to ensure teachers and school leaders have awareness of mental health issues and competence to support students experiencing mental ill-health. This has been done most notably through the “Mental Health Awareness Training Grants (MHAT)” and “Project Advancing Wellness and Resiliency in Education State Education Agency Grants (AWARE-SEA)”. In 2018, the amount of funding available through these opportunities totalled almost USD 59 million, while USD 31 million was made available in funding through AWARE-SEA in 2020 (SAMHSA, 2020[31]).

Preventing early school leaving is being prioritised in a few Adherents

137. When it comes to specific interventions and policies, there is progress in many Adherents to prevent early school leaving and provide non-stigmatising support. Recommendation (2d) calls for investing in the prevention of early school leaving and support for school leavers with mental health conditions. As outlined in *Fit Mind, Fit Job,* these efforts are crucial, as early school leaving is more prevalent among young people living with mental health conditions in comparison to those with no mental health conditions. Measures to address early school leaving are, therefore, an important ingredient of an integrated mental health, skills and work policy.

138. Preventing early school leaving is a priority for the European Commission, with all EU member states having committed in 2010 to reduce the share of early school leavers to under 10% by 2020. While progress has differed from country-to-country, the rate of early school leaving has continued to gradually decrease across the EU-28, and stood at 10.3% as of 2019 (Eurostat, 2021[32]). The priority placed on reducing early school leaving and supporting students to graduation is reflected in Hungary and Latvia where new policies have been implemented since 2015. Hungary is currently in the implementation stage of its “Mid-term Strategy against Leaving School without Qualification (2014-2020)”. Early warning and pedagogical support systems to prevent early school leaving were first introduced in November 2016, with the system monitoring risk factors for early school leaving such as absenteeism, difficulties in integration and underachievement. These factors closely align with the risk factors for mental ill-health. Once identified, at the school level, individual plans help students at risk through support that is coordinated and integrated with social workers, psychologists and child welfare services. To complement these implementation measures, teachers are trained on how to identify students at risk of early school leaving. In Latvia, the PuMPuRS project also provides individualised support to students at risk of early school leaving. By August 2020, the project – launched in 2017 with funding from the European Social Fund – had involved 527 educational institutions and created 43 695 individual aid plans.

Low-threshold and non-stigmatising mental health support go hand-in-hand with existing mental health services for children and young people

139. Recommendation (2c) calls for non-stigmatising support for children and youth living with mental health conditions. The policy questionnaire responses indicate that there are a number of well-integrated, external – in other words, out-of-school – and low-threshold mental health supports and services that have further developed in recent years. Such services usually take the form of youth centres that go hand-in-hand with in-school measures to support individuals with mental health conditions. These centres can help to avoid labelling young people as sick and problematic, and encourage them to seek support when showing first signs of mental ill-health, long before a mental health condition has been diagnosed.

140. Australia’s headspace centres offers a working example of a low-threshold service that already offered non-stigmatising support to young people aged 12 to 25. In the financial year 2018-2019, almost 100 000 young people visited a headspace centre and a further 32 000 accessed online and phone counselling through eheadspace. The number of headspace centres has been increased from 82 in 2015 to 112 in 2019, and additional funding of AUD 263.3 million from 2018-19 to 2024-25 was announced to

help meet the high demand for mental health services (Australian Government Department of Health, 2019[33]). As also discussed in Section 5.3.4, since 2016, headspace is being used as the delivery site for a pilot of integrated and individualised mental health and employment support for young people with mild-to-moderate mental health conditions.

141. Another example of a low-threshold service targeted at young people is Finland's *Ohjaamo* centres, which are one-stop youth guidance centres that offer integrated agency interventions including psychosocial support. Finland recently concluded a project to implement a national model of psychosocial support for *Ohjaamo* centres to ensure earlier identification of psychosocial issues. The Government has since decided to continue to support the project through 2021 and 2022.

Helping students in the transition to work

142. The policy questionnaire responses also indicate that a number of Respondents have taken action to support the transition from school to higher education and work, but the emphasis is often not directly placed on mental health. In Denmark, for example, a broad political agreement was reached in 2017 to reform the financing system of universities so that educational institutions are eligible for financial compensation for the extra time that some groups – such as students with disabilities – may need to complete their studies. While there is no explicit focus or mention of mental health in the policy itself, extra time can often enable and support students with mental health conditions to complete their degrees.

143. In contrast, the United Kingdom is taking measures to specifically support the mental health of youth in the transition from school to higher education. In 2019, the Department for Education set up a taskforce to support students in maintaining good mental health when starting university. The taskforce will focus on four main areas that can affect the mental health of students going into university, namely: independent living, independent learning, healthy relationships and well-being. The taskforce is in its initial phase with the focus currently on spreading existing good practices such as the "Transitions and Know Before You Go" initiative run by Student Minds, a mental health charity based in the United Kingdom.

144. In the United States, an interesting initiative is being run by "The Learning and Working During the Transition to Adulthood Rehabilitation Research & Training Center" at the University of Massachusetts Medical School. While this centre operates mainly in the health system, its focus is on supporting young people with mental health conditions in their transition from learning to working. For example, the centre has produced employment-related tips sheets for young jobseekers with mental health conditions that address practical questions such as "Do I Tell My Boss?", as well as a toolkit for employers of youth and young adult peer recovery workers. The US government was providing large-scale funding to the centre, through the Department of Health and Human Services, from 2014 to 2019.

5.3.3. Workplace policies: psychosocial risks at work are being addressed

145. Most Respondents reported taking action on workplace policies to reduce psychosocial risks at work and create more mentally healthy and safe working environments. Adherents have been making progress in this area through a mix of regulations relating to psychosocial risk assessment and prevention, and guidelines for employers and line managers to develop mentally healthy workplace environments as called for by the Recommendation. Yet at the same time, workplace policies are often not integrated with the mental health care system, or with employment services and the social protection system. This is most apparent in policies to address long-term sick leave, which continue to be steered by the social protection system and public employment services, with few obligations or incentives in place for employers to support return-to-work in many Adherents.

Box 5.6. Relevant extracts of the Recommendation on workplace policies

III.RECOMMENDS that Adherents, in close dialogue and co-operation with the social partners, seek to develop and implement policies for workplace mental health promotion and return-to-work. To this effect, Adherents should, as appropriate:

a) promote and enforce psychosocial risk assessment and risk prevention in the workplace consistent with applicable privacy and non-discrimination laws, with the adequate support of occupational health services, to ensure that all companies have complied with their legal responsibilities;

b) develop a strategy for addressing the stigma, discrimination and misconceptions faced by many workers living with mental health conditions at their workplace, with a focus on strong leadership, improved competencies of managers and worker representatives to deal with mental health issues, peer worker training, and active promotion of workplace psychological health and safety;

c) promote greater awareness of the potential labour productivity losses due to mental health conditions by developing guidelines for line managers, human resource professionals and worker representatives to stimulate a better response to workers' mental health conditions, covering ways to best assist those workers, including recognition and intervention with co-workers and advice on when to seek professional support, with due regard to personal privacy;

d) foster the design of structured return-to-work policies and processes for workers on sick leave, and their (prospective or current) employers, notably by promoting a flexible and gradual return to work in line with the worker's improving work capacity, with the necessary work and workplace adaptation and accommodations, and by using or experimenting with fit-for-work counselling services with a strong mental health component;

e) encourage employers to prevent and address overuse of sick leave by facilitating dialogue between employers, employees and their representatives and treating doctors as well as other mental health practitioners on how an illness affects the work capacity and how adjusted working conditions can contribute to a solution, with due regard to medical confidentiality.

The importance of workplace policies to promote mental health

146. Employers can play an important role in helping their employees to manage and deal with mental health issues and conditions. Workplaces are environments where most individuals spend a significant proportion of their lives, yet there remains both a lack of awareness and understanding of the impact mental health can have on the work of individuals and the labour productivity losses that can result from poor mental health among employees. This is why recommendation (3b) calls for strategies to address stigma and discrimination, while recommendation (3c) calls on support for employers in developing guidelines to help colleagues – line managers, co-workers and human resource professionals – and work representatives support individuals experiencing mental health issues.

147. The Recommendation also recognises the many layers of workplace policies required to both prevent the exacerbation of mental health issues and promote good mental health among all workers. While recommendation (1b) primarily calls on Adherents to promote the inclusion of psychosocial risks as a core component of occupational health and safety, the Recommendation also notes the importance of promoting mental health in the workplace so that all employees and workers can experience better mental health. These policies are of particular importance, as much like meaningful work can promote better mental health, poor-quality jobs, bad leadership and high job-strain can all contribute to stress in the workplace and the worsening of mental health among employees.

148. Many individuals of working age with mental health conditions often find themselves unable to continue working and thus resulting in prolonged sick leave, and in some cases, job loss and reliance on social benefits. This is why recommendation (1d) calls for the promotion of gradual or flexible return-to-work plans and counselling services with a strong mental health component, and recommendation (1e) encourages Adherents to work with employers to facilitate dialogue and find adjusted working conditions that can allow individuals with mental health conditions remain in employment.

Psychosocial risk is being increasingly integrated in occupational health and safety

149. Many Adherents have made significant progress in developing more comprehensive psychosocial risk prevention policies as called for in recommendation (3a), which emphasises the need to both promote and regulate psychosocial risk assessment and prevention in the workplace. In *Fit Mind, Fit Job*, a key finding was that implementation of such policies was slow and that traditional issues continue to dominate health and safety policies. The policy questionnaire responses indicate that most Respondents have moved beyond this stage, with many Adherents in recent years putting into place strategies and regulations, and offering guidelines to reduce psychosocial risks in the workplace.

150. Many Adherents have amended their regulations on occupational health and safety to incorporate psychosocial risks in a better way. In Canada, for example, a 2017 amendment to the Canada Labour Code makes explicit that occupational health and safety applies not only to physical injury, but also to psychological illnesses and injuries. Following on from this, in 2019, Canada announced it was going to take measures to require federally regulated employers to take preventative steps to address workplace stress. In Spain, Royal Decree-Law 8/2019 introduced mandatory registration of working hours, as a means to hold employers accountable for excessive work hours and unpaid overtime, both of which are risk factors for mental ill-health.

151. Japan, meanwhile, is a notable example of an Adherent that has placed stronger requirements on employers. Since December 2015, employers with more than 50 employees have been obliged to offer a "stress check" at least once a year. In 2018, 80.3% of employers offered the stress check (MHLW, 2019[34]). Based on the overall findings, employers are obliged to make their best efforts to adjust the work environment to reduce psychosocial stress. Japan has also linked the "stress check" policy to health services. If an employee is recognised as having high stress, they are entitled to request their employer to arrange an interview or consultation with a physician. The employer is then obliged to ensure such an appointment is arranged, and must adjust the individual's working conditions based on the findings of the physician as necessary. The use of questionnaires or tests to assess psychosocial risks in the workplace is also promoted in other Adherents, although most take a voluntary approach. For example, the National Institute for Safety and Health at Work in Spain, which operates under the Ministry of Labour, has developed a questionnaire and accompanying app known as FPSICO, which can be completed to provide insights into possible psychosocial risks in the workplace.

152. Many Respondents have also developed tools to support companies in implementing workplace psychosocial risk assessment and prevention. In Colombia, for example, the Ministry of Labour established not only a set of instruments for the evaluation of psychosocial risk factors in the workplace, but also a guide for the promotion, prevention and intervention on psychosocial risk, both of which were adopted in 2019. In Japan, meanwhile, a web portal called *Kokoro no Mimi* (Ears of the Mind) provides guidelines and tools for employers and managers to support the mental health of employees, and to implement the stress check. Meanwhile, in Spain, as part of the Spanish Strategy for Occupational Health and Safety 2015-2020, the government is developing new guidelines on the management of psychosocial risks. Such guidelines and tools can help businesses and employers implement measures that align with regulation on reducing psychosocial risks at work.

153. Where Adherents differ is in how broadly they look at mental health in the workplace. In many Adherents, these measures are primarily designed to prevent mental health conditions from arising. By defining mental health policy in the workplace narrowly, this preventative approach may only bring benefits for individuals who experience clinically significant symptoms of mental health conditions. In comparison, there are significantly fewer Adherents seeking to promote better mental health for all employees.

154. The United Kingdom and Canada stand out as two Adherents that are taking this broader approach to mental health policy in the workplace. In the United Kingdom, the government is implementing recommendations from Thriving at Work: the Stevenson/Farmer review of mental health and employees,

which was commissioned by the Prime Minister and published in 2017. The review called for emphasis on ensuring mentally healthy workplaces rather than simply dealing with mental health issues when they arise. All recommendations from the review were subsequently accepted by the government, and working closely with leading charities, employers and interagency cooperation, a set of six Mental Health and Work standards were developed that any employer can follow to support the mental health of their employees, as well as tips on how to implement these standards. In a similar vein, Canada's National Standard for Psychological Health and Safety, which is discussed in detail in Box 5.7, provides guidelines on how to promote more psychologically healthy and safe work environments for all employees.

Box 5.7. National Standard for Psychological Health and Safety in the Workplace - Canada

Canada's National Standard for Psychological Health and Safety in the Workplace (the Standard), first established in 2013, is a set of voluntary guidelines that support employers in developing "psychologically healthy and safe work environments for their employees". The *Standard* aims to contribute to broadening understanding of Occupational Health and Safety by "shifting workplace culture to value mental health and safety as much as physical health and safety".

Compared to other frameworks on mental health in the workplace, the Standard is much broader, and identifies 13 factors for improving psychological health and safety in the workplace. For example, instead of simply focusing on more narrow factors such as workload management and access to counselling, the Standard also stresses the importance of factors such as organisational culture, providing opportunities for employees to grow and develop, and developing workplace environments where employees feel they are connected to their day-to-day work.

Although the Standard predates the Recommendation, in recent years, Canada has developed implementation guidelines and tools to support employers in translating the guidelines into changes in the workplace. In 2017, for example, the Mental Health Commission of Canada (MHCC) concluded a three-year project to look at how 40 organisations of varying size from different industries and sectors were implementing the Standard. The report from this project identified a number of good practices, as well as factors that may facilitate or act as barriers to implementing the Standard.

The Standard has also been accompanied by a set of animated videos developed in 2016 by the MHCC in partnership with Ottawa Public Health that seek to raise awareness of the 13 factors that can affect mental health in the workplace. Instead of simply raising awareness, the videos provide a thorough and detailed explanation of the interlinkages between workplaces and mental health with individual videos for each of the 13 factors. These videos have been integrated into the broader have THAT talk series developed by Ottawa Public Health that aims to raise awareness of the importance of mental health more broadly.

A 2019 poll by Ipsos found that while only a small proportion of employees are aware of the Standard, employees working for organisations that implement the Standard are far less likely to say their workplace is psychologically unhealthy or unsafe (5%) compared to organisations not implementing the *Standard* (13%). Furthermore, at organisations that implement the *Standard*, employees who have experienced depression took less days of work (7.4 days per year) than the average employee experiencing depression (12.5 days per year). This indicates that the Standard may already be contributing to an improvement in the mental health of employees.

Source:
National Standard of Canada: Psychological health and safety in the workplace (2013), Mental Health Commission of Canada
Workplaces that are Implementing the National Standard of Canada for Psychological Health and Safety in the Workplace Described by Employees as Psychologically-Safer Environments (2017), Ipsos, https://www.ipsos.com/en-ca/news-polls/workplaces-implementing-national-standard-canada-psychological-health-and-safety-workplace
Case Study Research Project Findings: 2014-17 (2017), Mental Health Commission of Canada, https://www.mentalhealthcommission.ca/sites/default/files/2017-03/case_study_research_project_findings_2017_eng.pdf

155. One of the main recommendations from the Stevenson/Farmer review was to implement standards on healthy workplace environments within the Civil Service (2017[35]). As a leading employer, it is hoped that the Civil Service can demonstrate good practices for other employers to follow. Since the release of the independent report, the Civil Service has held its own mental health conference that aims to exchange and embed mental health best practices across the Civil Service. One such best practice may be the decision by HM Revenue & Customs to double the number of Mental Health Advocates (MHAs) available to ensure more colleagues can receive individualised face-to-face support.

More can be done to support return-to-work and reduce preventable sick leave

156. Increasing evidence from studies in a number of Adherents shows that combining workplace measures with clinical interventions is more effective than isolated workplace or clinical treatment at supporting employees experiencing mental health issues to remain in and return to work, and thus that integrated support can both prevent and shorten absences due to sickness (Nieuwenhuijsen et al., 2020[36]). This confirms and provides support to the Recommendation's emphasis on promoting timely return-to-work and reducing preventable sick leave of those experiencing mental health conditions. Despite this, there has been limited progress to reduce preventable sick leave, and even in cases where there are promising initiatives, these tend to be focused on adjustments to the social protection system as opposed to strengthening the role of employers for addressing mental health issues of employees on sick leave.[11]

157. Austria and Denmark have implemented new measures and reforms of the social protection system to prevent long-term sick leave that should be followed closely. In Austria, a new model to promote part-time return to work (WIETZ) was introduced in 2017 that closely aligns with recommendation (3d) which calls for the promotion of more flexible return-to-work. In this model, workers are entitled to shorter working hours and financial protection to support reintegration into the labour market after prolonged sick leave. Since its introduction, more than 7 300 individuals have used the WIETZ model to return to work. Although WIETZ is not exclusively for individuals with mental health conditions, mental ill-health is the most common reason for prolonged absence from work among WIETZ applicants.

158. Meanwhile, Denmark launched a project in 2015 to trial a model to support return-to-work called IBBIS. The IBBIS model offers integrated support from case managers in the social protection system, employment consultants and healthcare professionals to support individuals with mild-to-moderate mental health conditions – depression, anxiety and stress orders – return to work after prolonged sick leave (Mental Health Services in the Capital Region of Denmark, 2020[37]). This project has since been further updated to IBBIS II, and will continue through to 2022. This is a rare example of integrated employment and mental health support that is specifically targeted at individuals on sick leave, as opposed to jobseekers who do not work.

159. In contrast to reform of social benefits and employment services, policies to incentivise or require employers to prevent long-term sick leave were rarely mentioned in the policy questionnaire responses. This suggests the continuation of a worrying trend mentioned in *Fit Mind, Fit Job*: employers are only held responsible for the mental health of their employees while they are still at work. This may also reflect a lack of clarity on the roles and responsibilities for ensuring support for return-to-work – in many Adherents, after a period of prolonged sickness absence, there appears to be a gap between the point where employers are responsible and where the support of the employment service and social protection system kicks in.

[11] Although this concerns reform of the social protection system, the policy is about getting individuals who are on sick leave – technically still in employment – back into work and is thus included in the workplace section of the Recommendation. By comparison, reforms targeted at individuals who are already out of work and seeking employment are covered in the social benefits and employment services section of the Recommendation.

160. There are a few examples of stronger requirements and incentives for employers to support return-to-work among employees on sickness absence, but most pre-date the Recommendation. In the Netherlands, employers are obliged by law to provide payment of at least 70% of wages for two years to their employees on sick leave (OECD, 2015[2]). Furthermore, by 2015, in the Netherlands, Norway and Sweden, employers and their corresponding employee both had responsibilities to agree to return-to-work action plans after around eight weeks of sick leave. However, these Adherents remain exceptions to the norm.

161. In the questionnaire responses, only Sweden explicitly mentioned measures it had taken to increase the role of employers in supporting return-to-work. Since July 2018, employers in Sweden have been required to draft return-to-work plans for employees within 30 days of onset of sickness absence for employees who are not expected to return to work within 60 days of onset of absence. Employers in Sweden can now also apply for a grant from the Swedish Social Insurance Agency to subsidise costs related to providing workplace-oriented rehabilitation. These combined efforts should provide further encouragement to employers to take greater responsibility in supporting their employees return to work.

5.3.4. Social benefits and employment services: incentives are being aligned with return-to-work but individualised support remains a challenge

162. Across all Adherents, recognition of the key role of the social protection system in fostering an integrated policy approach to mental health remains limited. In the few examples where social benefits and employment support have a focus on integrated health and employment support, this is generally targeted at (and limited to) severe mental health conditions – through either a focus on mental health within disability policy, or investments in supported employment (Individual Placement and Support). Although efforts to improve the mental health competence of caseworkers and other actors have been made in recent years, it seems that the high prevalence of mild-to-moderate mental health conditions among people receiving benefits is yet to be fully recognised and reflected in policy in most Adherents.

Box 5.8. Relevant extracts of the Recommendation on social benefits and employment services

IV.RECOMMENDS that Adherents seek to improve the responsiveness of social protection systems and employment services to the needs of people living with mental health conditions. To this effect, Adherents should, as appropriate:

a) reduce preventable disability benefit claims for mental health conditions through recognition of the (possibly reduced or partial) work capacity of those potentially claiming a benefit, using appropriate tools and methods to identify work capacity, and through a focus on early identification and early provision of medical and/or vocational support as necessary;

b) help jobseekers living with mental health conditions into work through appropriate outreach tools to identify an adequate support process that facilitates access to employment services and training as well as services that address the labour market barriers associated with a jobseeker's mental health condition;

c) invest in mental health competences for those administering the social protection system by providing training for caseworkers, social workers and vocational counsellors to improve their understanding of mental health issues and the health benefits of work and by ensuring adequate co-operation of benefits, social services and employment services offices with psychological coaches;

d) encourage the integration of mental health treatment into employment service delivery by stimulating cooperation of employment services with the health sector, especially primary and community-based mental health professionals, and by encouraging the development of evidence-based vocational interventions for jobseekers with mild-to-moderate mental health conditions which combine psychological counselling with pre- and post-placement services or work experience programmes.

Why employment services and social benefits need to take mental health into account

163. *Fit Mind, Fit Job* showed that mental ill-health places significant pressure on social benefits and employment services of OECD countries. Mental health conditions are prevalent not only among disability

benefit recipients, but also among recipients of unemployment benefits and social assistance. Across the OECD, between one-third and one-half of all benefit recipients experience mental health conditions, and the longer people receive social benefits, the higher the prevalence of mental ill-health, reflecting at least in part, the negative effects that joblessness can have on mental health.

164. These pressures on social benefits and employment services are rising further as awareness of mental health conditions continues to grow. A dual challenge therefore exists to not only better support individuals with mental health conditions in the social protection system, but also to alleviate the increasing pressure placed on the system, and in particular on disability benefits. As the Recommendation makes clear, however, by improving the responsiveness of social benefits and employment services to the needs of individuals experiencing mental ill-health, this dual challenge can be addressed.

165. For example, recommendation (4a) calls for better recognition of possible work capacity – even if this is reduced or partial – of those potentially claiming benefits for reasons related to mental health, as this not only reduces pressure on the disability system but can also bring benefits for individuals experiencing mental health conditions as meaningful employment can be beneficial for mental health.

166. Recommendations (4b) and (4c) call for more specific policy actions to improve social benefits and employment services for individuals experiencing mental health conditions. Recommendation (4b) calls for specific support to help jobseekers into work, while recommendation (4c) calls for a strengthening of the mental health competence of those administering employment support and social benefits – including caseworkers, social workers and vocational counsellors.

167. Recommendations for the social protection system are also closely tied to recommendations on promoting return-to-work (3d) and preventing and addressing, where possible, long-term sick leave (3e) as prolonged absence from work – especially for individuals with mental health conditions – can result in individuals becoming removed from the labour market and reliant on social benefits.

Rules and legislations are being reformed to encourage and support return-to-work

168. A number of Respondents have undertaken significant reforms to rules and legislation in social benefits and employment services to incentivise jobseekers experiencing mental health conditions to return-to-work. For example, Canada amended its Employment Insurance (EI) rules effective August 2018 to extend to maternity and sickness benefits. This provision allows EI claimants to work while receiving benefits by providing mothers and those dealing with illness or injury with greater flexibility to gradually return to work. These EI claimants can keep 50% of their benefits for every dollar earned, or up to 90% of previous weekly insurable earnings used to calculate their EI benefit amount. Although not directly targeted at individuals experiencing mental health conditions, this change supports jobseekers financially, including those with mental health conditions, to gradually return to full-time work without risking the loss of benefits.

169. In Finland, the recently launched work ability programme will adjust rules on benefits to allow individuals with partial working capacity – such as individuals experiencing mental health conditions – to gradually return to work while keeping part of their existing unemployment benefits. Furthermore, in Lithuania, in-work benefits have been extended so those registered as unemployed for at least six months can keep half of their benefits temporarily after finding work. These reforms in Canada, Finland and Lithuania are promising measures that follow in the footsteps of Sweden and Norway, which were identified as countries already supporting gradual return to work in *Fit Mind, Fit Job*.

170. The policy questionnaire responses also indicate that some Respondents have recently reformed work capacity assessments by shifting towards identifying capacity – even if partial – and away from disability. For example, in Estonia, the government has recently started to reassess workers on disability benefits to identify individuals with partial work capacity. Initially, in 2016, the measure was implemented on a voluntary basis, but since 2017, individuals with partial work capacity have been required to register as unemployed. Most importantly, the recognition of their work capacities opens up channels to specific

and well-targeted employment support. Early signs are promising as many of the initial participants have chosen employment support that is usually targeted at the unemployed, such as training, work trials and work-related rehabilitation (Browne et al., 2018[38]). Estimates from the Ministry of Finance suggested that by 2022, an extra 19 100 people would be in employment and 16 400 more people actively looking for work due to the reform.

Individual Placement and Support programmes need to be scaled up

171. *Fit Mind, Fit Job* noted that there were a number of promising examples of employment support being combined with mental health care especially through Individual Placement and Support (IPS), a proven evidence-based practice in which multidisciplinary mental health teams including an employment specialist provide coordinated health and employment support for jobseekers in finding and sustaining employment in a competitive setting. The participants are usually individuals who receive mental health treatment through specialist mental health and addiction services.

172. The policy questionnaire responses indicate that IPS has become more widely implemented across the OECD. This has been mainly throughout trials to test and evaluate IPS programmes for jobseekers with severe mental health conditions. There are ongoing or recent IPS trials in Adherents including Denmark, Ireland, Italy, the Netherlands and New Zealand, while in Finland, trials are set to begin in the coming years. Such trialling and evaluation has proven the effectiveness of the IPS approach across multiple Adherents. For example, in both Australia and Denmark, recent studies have shown that IPS programmes result in positive employment outcomes for participants, while there are also similar well-established findings in Adherents such as the United States that predate the Recommendation. Given that IPS has proven to be effective in multiple countries based on decades of research, Adherents would benefit more from scaling up or rolling out IPS, rather than continuing to pilot the standard IPS approach. Despite this, the policy questionnaire responses suggest that very few Adherents have scaled up IPS trials and/or included them in national mental health strategies.

173. The challenge of scaling up IPS may indicate that while beneficial for the jobseeker receiving support, the approach might be considered too resource-intensive or too ambitious to be implemented at the national or regional level, even if it is cost-effective. IPS is rarely mentioned in mental health plans, with a few exceptions such as England (United Kingdom), where the NHS has committed to supporting 55 000 people per year with severe mental health conditions in finding and retaining employment by 2023/24. This may be because some of the principles of IPS which are usually strictly adhered to, such as time-unlimited supports, may not be easily met as IPS is scaled up. This has driven attempts to develop modified versions that may be less costly or easier to implement.

174. One of the policy questionnaire responses mentioned a modified version of IPS, Italy’s Traineeship as a Springboard out of Unemployment for those Affected by Mental Illness (TSUNAMI) project. The key premise of this project is to place participants in organised internships and traineeships lasting three to six months where participants can gain real-world experience in competitive employment settings. As the name of the project indicates, the aim was to assess whether such experience in internships and traineeships could then be used to upskill participants such that they can use the experience as a springboard from which to find competitive employment. It will be critical to evaluate the long-run impact of the project, as the effects on labour market outcomes are unlikely to be seen immediately.

There remains a shortage of individualised support for individuals receiving employment benefits with mild-to-moderate mental health conditions

175. A further limitation with IPS is that it usually focuses exclusively on supporting individuals with severe mental health conditions find employment. As a result, such individualised support is provided mainly to individuals who are recipients of disability benefits due to their existing mental health condition. This was also reflected in the policy questionnaire responses, as many of the responses interpreted the

section on social protection systems exclusively as referring to disability policy. In comparison, there remains a lack of comparable integrated mental health support for recipients of unemployment benefits, many of whom may have diagnosed or undiagnosed mild-to-moderate mental health conditions.

176. This approach to mental health support does not reflect the fact that there are likely more individuals with mental health issues receiving unemployment than disability benefits. As shown in Annex B, among recipients of benefits who are experiencing mental distress in the OECD countries for which there is data, 37% are on unemployment benefits compared to 33% that are on disability benefits. This distribution varies across Adherents. In Denmark, Germany, Spain and Austria, individuals experiencing mental distress are more likely to receive unemployment benefits, whereas in Estonia, Switzerland and Norway, individuals experiencing mental distress are more likely to receive disability benefits. Nonetheless, across the OECD, mental health support and services need to be available in all areas of the welfare and social protection system.

177. There are a few exceptions of integrated support directed at individuals with mild-to-moderate mental health conditions, often modelled on IPS, although these tend to still only be pilots or trials. In Australia, for example, a pilot launched by the Department of Social Services in 2016 aimed to provide IPS for around 2 000 young people every year – targeting individuals with mild-to-moderate mental health conditions – through headspace services. An evaluation has found that the programme is effective in improving the education and employment outcomes of these young people (KPMG, 2019[39]), and a literature review has been conducted to assess potential adjustments to further strengthen the effectiveness of IPS programmes for young people. A cost-benefit analysis of the trial in 2020 found that while the implementation of IPS requires additional investment compared to existing employment services under "jobactive", the benefits gained in terms of reduced welfare payments and increased personal income far outweigh the additional costs (KPMG, 2020[40]). Given its success so far, in October 2020, the government announced a further expansion of the trial to a further 26 sites and the continuation of the trial in existing 24 sites through to June 2024. Similarly in both Wales and England (United Kingdom), IPS pilots that target individuals with mild-to-moderate mental health conditions are currently being implemented. The pilot in Wales was launched in June 2019 and targeted individuals who have worked for some time within the past 12 months and who are actively seeking work. An evaluation of the pilot will be released this year.

178. The next step is to scale up the small number of promising examples to provide more widespread and timely access to treatment. While evidence on the effectiveness of IPS remains strongest for participants experiencing severe mental health conditions, these examples show that many Adherents would also benefit from expanding access to IPS to individuals experiencing mild-to-moderate mental health conditions. The relative lack of promising recent examples of individualised support for this group within the social protection system also indicates a concerning trend – that employment services and social benefits may still approach employment support as only necessary once individuals have been "treated and cured" for their mental health conditions. Such an approach, if still widespread, overlooks that meaningful employment is often a crucial element of treatment and recovery.

Workers in the social protection system are increasingly trained in mental health awareness, but policies need to go beyond disability services

179. A number of Respondents – such as Australia, Czech Republic, Latvia, Lithuania, New Zealand and Switzerland – have put in place measures to provide mental health training to staff in employment services and social benefit offices. However, much like all other mental health policies in the social protection system, initiatives are primarily geared towards individuals on disability benefits. Unlike in schools, workplaces and health systems, the front-line actors in social protection systems tend to be more diverse as individuals with mental health conditions are often connected to different parts of the system. Given that individuals experiencing mental health conditions receive a range of income-support payments

and benefits as shown in Figure A B.20, ensuring mental health literacy and competence across the different parts of the social protection system, including among caseworkers administering unemployment benefits, remains crucial going forward.

180. For example, in Latvia, a framework is being implemented to train municipal social service workers who work with adults with disabilities related to mental health conditions. By 2023, it is expected that up to 180 social workers will have participated in an intensive six month training programme focused on providing support for adults with intellectual disabilities and experiencing mental health conditions. Meanwhile, in Australia, starting in July 2020, the National Disability Insurance Scheme has made support from psychosocial recovery coaches available for participants with psychosocial disabilities. The role of the recovery coach is to support participants in living a fuller and contributing life, including through supporting linkages with broader services including employment and education (NDIS, 2020[41]).

6. Summary and conclusions

6.1. Key conclusions on the implementation of the Recommendation

181. Over recent years, many Adherents have introduced mental health plans and strategies in line with the Recommendation with a focus on mental health policies integrated with education, employment, social and health policy. However, further progress is needed in the implementation of such plans and the enforcement of legislation at the working level, which is often lagging behind.

182. Policy development is also highly uneven across the four thematic areas (health systems, youth support systems, workplace policies, and social protection systems). There is significant recognition in youth support systems of the need for an integrated approach that responds to mental health and its impact on education and, subsequently, employment. On the contrary, fewer initiatives can be found across Adherents in the social protection system that systematically link and integrate mental health and employment services. Workplace and health policies take an intermediary position in terms of more integrated policy development.

- Health care systems are increasingly prioritising mental health and, in most Adherents, there is an increased recognition of integrating mental health care treatment with youth, workplace and employment interventions. Such efforts still seem to be often at the strategy level, however, and examples of working-level implementation of integrated mental health, skills and work policy in the health care system are still relatively limited owing to structural barriers to integration.
- Youth policies and interventions appear most innovative, with easy and often timely access to low-threshold services both within and outside of school that address social, health, education and employment needs of young people with and without mental health conditions. This seems to reflect the prioritisation of child and adolescent mental health among Adherents, in both strategic plans and at the working level.
- Workplace policies also reflect the need for a more integrated approach that addresses workers' mental health and employment challenges concurrently. Despite this, workplace policies implemented by governments remain largely focused on psychosocial risk prevention, often overlooking the importance of other aspects of mental health in the workplace. Mental health support for individuals on sick leave remains inadequate – this may be the result of lack of clarity over where responsibility for mental health support switches from the employer to the employment services and social protection.
- Welfare systems – employment services and social benefits – appear to be lagging significantly behind in most Adherents in developing and implementing integrated mental health, skills and work policy, especially for individuals with mild-to-moderate mental health conditions. Such conditions are highly prevalent among benefit recipients and employment service users. In isolated cases of integrated services for individuals with mild-to-moderate mental health conditions, the initiative tends to come from the health system. It is unclear what is stopping governments from investments in scaling up integrated health and employment services that have shown good results.

183. Policy development is also uneven across the three critical elements for an integrated mental health, skills and work policy: *who* intervenes, *when* to intervene, and *how* to intervene. Substantial progress has occurred in many Adherents in equipping front-line stakeholders such as teachers, managers, caseworkers or general practitioners with better mental health competence and increasingly also with knowledge on the links between mental health, education and employment (the "who"). Shifts to prevention and early identification of the need for support and corresponding cost-effective early intervention are happening in some Adherents and in some policy areas, although timely intervention is often still confined to silos and need to become more integrated (the "when"). Finally, the development of integrated mental health, skills and work policies and the provision of truly integrated health, education and employment interventions is still rare (the "how" or "what"). This suggests that the emphasis of the Recommendation on the importance of integration remains pertinent.

184. Such uneven progress across the *who*, the *when* and the *how* can be problematic, as the development of integrated mental health, skills and work policy is dependent upon success on each of these three dimensions. For instance, Adherents may make great progress in reducing waiting times for mental health treatment and providing more timely treatment (thus seeking to address "when"). However, the value of such progress can be further amplified by ensuring that treatment is integrated with employment support in cases where mental health conditions have resulted in job loss (thus addressing the "how"). Insofar, even slow progress in integrated, timely and appropriate polices and services – linking the when, how and who – may deliver better outcomes for persons experiencing mental health conditions and thus also for the society than relatively fast progress in just one element of policy.

185. The questionnaire responses also suggest that Adherents are in very different stages in the development towards integrated mental health, skills and work policy, and even within Adherents, policy development is often more advanced in some thematic areas than in others. Based on the responses, many Adherents may be categorised as falling into one of the following four stages:

- **Stage 1: Developing the right rhetoric:** Adherents in this stage often lack a national mental health plan, and even where they do, show little to no focus on developing integrated mental health, employment and skills services. These Adherents tend to have only recently started focusing on mental health policy and stigma against individuals with mental health conditions is highly prevalent. Policy priorities in this stage tend to focus on expanding capacity for community-based mental health services and in some Adherents, raising public awareness of mental health.
- **Stage 2: Building the foundations for integrated mental health, skills and work policy:** Adherents in this stage have national mental health plans that emphasise the need for integrated mental health, employment and skills services, but there remain only trials and small-scale policies that provide these integrated mental health services within and outside the health system. Policy priorities in this stage tend to remain focused on the expansion of community-based mental health services and awareness raising, while in parallel, placing emphasis on building the foundations for integrated mental health, skills and work policy.
- **Stage 3: Shifting from trials to a scaled-up integrated approach:** Adherents in this stage have established mental health plans and strategies for integrated mental health, skills and employment service delivery. In this stage, effective and innovative trials and small-scale policies to provide integrated mental health services are widespread, but such trials are often not scaled-up. Adherents in this stage tend to have reached a baseline level of public awareness and primarily rely on community mental health services to support individuals with mental health conditions. Policy priorities in this stage differ somewhat across Adherents, but among those making the most progress, significant emphasis is placed on scaling up integrated mental health policies and addressing structural challenges that prevent inter-agency coordination.

- **Stage 4: Integrated mental health, skills and work plans in practice:** Adherents in this stage are executing well-developed integrated mental health, skills and work plans through large-scale evidence-based treatments and interventions – although progress tends to be uneven across the thematic areas. In this stage, mental health performance indicators that go beyond the health care system – such as employment targets – are not only being increasingly developed, but are also included within national mental health plans. Adherents in this stage are at the forefront of implementing integrated mental health, skills and work policy among OECD Member countries. Policy priorities at this stage focus on further extending the availability of integrated mental health, skills and employment services and filling in specific gaps that exist in support for individuals experiencing mental health conditions.

186. Although many Adherents may not clearly fit into any particular stage, also because policy is more advanced in one area (e.g. youth policy) than in another one (e.g. welfare policy), the stages may provide a useful frame of reference to see where they currently stand. The stages are not reflective of any particular path that a country or Adherent ought to take, but instead, describe the steps that appear to be taken by many Adherents in the development of an integrated mental health, skills and work policy. Where possible, Adherents can and should aspire to take multiple steps at a time in increasingly integrating and scaling up their mental health policies. For example, almost all Adherents, if they have not done so already, could put in place a plan that aims for an integrated mental health, skills and work policy to be implemented in the long run and begin to put in place integrated services at the working level. Box 6.1 and Box 6.2 below provide useful examples of how mental health policies, plans and services have developed or are developing along these stages over the past twenty years in Colombia and New Zealand – two Adherents at different stages of policy development, offering good lessons for other Adherents to follow.

Box 6.1. Policy Developments in Mental Health in Colombia, 1998-2020

1998: the first *National Policy of Mental Health* is adopted under the General Health Social Security System. The policy encompasses prevention, screen and mental health services, but there is difficulty executing the plan due to reasons including a lack of funding.

2005 and 2007: the Ministry of Social Protection publishes the *Guidelines of Policy of Mental Health in Colombia* in 2005 and the *National Policy of the Field of Mental Health* in 2007. These look to build upon the 1998 law but are only guidelines on how to develop mental health policy.

2007: the ***2007-2010 National Public Health Plan*** identifies improving mental health as a priority issue, but the focus remains largely on the health system. The most notable target in the plan is to reduce the consumption of psychoactive substances in all territorial entities.

2013: ***Law 1616 on Mental Health*** modifies and updates the *National Policy of Mental Health* of 1998. The law outlines the rights of people with respect to their mental health, and sets out priorities including prevention of mental illness, promotion of mental health and an integrated approach to mental health. In this law, the term integrated refers largely to integration within the health system. Shades of a more integrated approach to mental health are becoming apparent, with the law including a specific Article on the promotion of mental health in the workplace. The Law also calls for the development of a National Mental Health Council, which meets for the first time in 2016.

2013: Colombia adopts the ***2012-2021 Ten-Year Public Health Plan*** in March. This plan makes mental health a priority area and adopts an approach that recognises that socioeconomic inequalities have significant impact on health, including for mental health. This results in an emphasis on what is referred to as “coexistence and mental health”.

2018: Colombia releases its new and latest ***National Mental Health Policy.*** The concept of “coexistence and mental health” is fully embedded in this policy, which calls for policies to ensure the inclusion of people with mental health issues in educational, social and workplace environments. The plan includes a multi-level governance strategy with shared responsibilities between different levels of government.

2019: Colombia releases the **Integral Policy for the Prevention and Care of the Consumption of Psychoactive Substances.** This plan recognises the close interlinkages between mental health and the consumption of psychoactive substances, and thus shares five common work lines with the National Mental Health Policy. These are a) promotion of good mental health, b) prevention of mental illness, c) integral treatment, d) integral rehabilitation and social inclusion, and e) sectoral and inter-sectoral management.

2020: the National Council of Economic and Social Policy on Mental Health (CONPES) releases the ***2020-24 Strategy for the Promotion of Mental Health***. The strategy is notable for the wide range of government agencies involved and the specific mandates given to each government agency. The Strategy reflects an integrated approach to mental health that takes into account the social, employment and educational dimensions of mental health policy.

Sources: Plan Nacional de Salud Pública 2007-2010 (2007), Ministry of Social Protection, https://www.paho.org/hq/dmdocuments/2010/Politicas_Nacionales_Salud-Colombia_2007-2010.pdf
Ten-Year Public Health Plan 2012-2021 (2020), Ministry of Social Protection, https://www.minsalud.gov.co/English/Paginas/Ten-year-public-health-plan.aspx
Ley 1616 de 2013 (2013), Congress of Colombia
Política Nacional de Salud Mental (2018), Ministry of Health and Social Protection, https://www.minsalud.gov.co/sites/rid/Lists/BibliotecaDigital/RIDE/VS/PP/politica-nacional-salud-mental.pdf

Box 6.2. Policy Developments in New Zealand, 1996-2020

1996: New Zealand establishes the Mental Health Commission after an inquiry (commonly known as the Mason Inquiry) in the mid-1990s into mental health services. The Commission is given a mandate to provide independent advice to the Minister of Health. The inquiry also calls for funding for an anti-stigma campaign. This results in the launch of the Like Minds, Like Mine programme, making New Zealand one of the first countries to put in place a national programme to address stigma against individuals with mental health conditions. Like Minds, Like Mine has come to be considered a "gold-standard" and plays a key role in raising awareness and understanding of mental health issues. The Like Minds, Like Mine anti-stigma programme exists to this day.

1998: the Blueprint for Mental Health Services sets out developments required to implement the National Mental Health Strategy, first published in 1994. The Blueprint was notable for its use of a recovery approach, which emphasises the need to support individuals with mental health conditions participate in society. This meant adopting a more community-oriented and inter-sectoral approach to decreasing the prevalence of mental health conditions. The focus is on people most severely affected by mental health issues (the "3%"), and thus also on specialist mental health services.

2005: the *Te Tāhuhu*: Second New Zealand Mental Health and Addiction Plan is released. Combined with the Primary Health Care Strategy of 2001, these documents signal a shift towards the provision of primary mental health services and more timely treatment. Primary Health Organisations (PHOs) funded by District Health Boards (DHBs) are developed to provide essential primary health services, including mental health services, largely through general practices.

2008: funding is allocated for the first time for nurse-led school-based health services (SBHS) in secondary schools with an emphasis on improving youth mental health through HEEADSSS Wellness Checks. The scheme is first rolled out in schools attended by young people of highest need (decile 1 and 2), and continues to be expanded today. This year also marks the launch of Mental Health 101 (MH101), a national mental health literacy programme offering one-day workshops to increase competence of individuals in contact with people with mental health conditions.

2012: further strategic documents (Rising to the Challenge, Blueprint II and Towards the Next Wave) are published that set the direction for mental health policy. The documents make clear that policy needs to go beyond the 3% and provide better support for individuals with mild-to-moderate mental health conditions. The documents mention the social determinants of mental health, including the importance of labour force participation, but do not provide explicit guidance on how to better integrate individuals with mental health conditions in the workplace.

2018: the *He Ara Oranga*: Inquiry into Mental Health and Addiction takes place. The inquiry process is a public consultation that also involves the OECD, which publishes Mental Health and Work: New Zealand. The key findings of the inquiry closely relate to the Recommendation and OECD country review, which include the need to better support the needs of the "missing middle" of people with mild-to-moderate mental health conditions, the need to take a whole-of-government approach to mental health policy and a call to strengthen NGOs.

2019: the Government publishes its official response to the Inquiry and the OECD report. Of the 40 recommendations in *He Ara Oranga*, 38 are accepted, accepted in principle or agreed to further consideration. 18 of the 20 OECD recommendations are accepted, accepted in principle or agreed to further consideration. New Zealand's first Wellbeing Budget also identifies mental health as one of its five priority areas, resulting in record levels of investment in mental health and a shift in mental policy to reflect the key recommendations from the Inquiry process.

Source: OECD (2018), Mental Health and Work: New Zealand, Mental Health and Work, OECD Publishing, Paris, https://doi.org/10.1787/9789264307315-en.

6.2. Key conclusions on the dissemination and use of the Recommendation

187. A key takeaway from this report is that going forward dissemination efforts should be strengthened by both the Secretariat and Adherents. Based on the responses to the follow-up questionnaire, it seems the extent to which the Recommendation had been disseminated varied significantly across Respondents, and across stakeholders within Respondents. This means there remains significant room to increase the awareness of the Recommendation among all stakeholders. The level of awareness appears to be lowest in the non-governmental sector, public employment services, employer representatives and the education sector. To boost the visibility and awareness of the Recommendation, Adherents could consider translating the Recommendation into their own language and the Secretariat could look into preparing flyers or other tools that may help to disseminate the Recommendation and its key policy principles.

188. The report also finds that the Recommendation could be used more to inform policy developments. Responses to the follow-up questionnaire on the use of the Recommendation varied significantly, with some Adherents stressing the Recommendation had already proven very useful, while other Adherents were unable to specify how useful the Recommendation had been in advancing policy reform. When asked what kind of measures they would like to see the OECD to take going forward, Adherents noted that workshops, indicators and an informal group of experts could all prove useful in supporting them in the implementation and use of the Recommendation. The report also specifically identified country reviews as potentially effective vehicles to translate the Recommendation and its principles into policy reform. Adherents are invited to consider undergoing individual country reviews using the Recommendation as a framework.

6.3. Continued Relevance

189. A majority of Respondents to the follow-up questionnaire considered the Recommendation to be "highly relevant" going forward as discussed in Section 4.2. This confirms the continued relevance of the Recommendation. When asked whether they considered how the context of the COVID-19 crisis had changed the importance of the Recommendation in the follow-up questionnaire, 60% of Respondents stated that the Recommendation had become "more important" and the remaining 40% responded that there had been "no change". Among Respondents stating that there was "no change" in the importance of the Recommendation, a common sentiment was that the Adherent already recognised the high importance of the Recommendation from before the crisis. No Respondent reported that the context of the COVID-19 crisis had made the Recommendation either "less important" or "not important at all".

190. The Secretariat has carried out an initial analysis on the impact of the COVID-19 crisis on mental health, and suggested measures that countries could take to better support the mental health of citizens through integrated mental health, skills and work policy, which will be released in a forthcoming brief (OECD[42]). Across Adherents for which data is available, evidence points to a marked increase in the prevalence of mental health conditions such as anxiety and depression amidst the COVID-19 crisis. While risk factors for mental ill-health such as financial insecurity and unemployment have intensified, protective factors such as social connections, schooling, work routine and access to health services have weakened.

191. Looking ahead, however, the specific longer-term and structural impacts of the COVID-19 crisis on mental health are less clear, and by extension, it remains to be seen how mental health policies will have to adjust or evolve. Recommendations are designed for longer-term goals, and thus, revisions to the Recommendation should only be made once due consideration has been given to the longer-term consequences of the COVID-19 crisis. This will mean that the coming months and years provide a timely opportunity to consult experts from health systems, education and youth support systems, workplaces and employment, and social protection systems on possible revisions to the Recommendation.

192. Nevertheless, it can be suggested that there may be four broad long-term impacts of the COVID-19 crisis on mental health policy, which could have implications for the Recommendation. First, the COVID-19 crisis may change how mental health services are delivered or provided. Second, the major disruptions caused to learning and working are likely to have long-term implications for mental health policy given the interlinkages of mental health with educational and skills outcomes. Third, the impetus from remote learning and teleworking may accelerate transformation in how we learn, work and live, which will likely have profound implications on the working level integration of mental health policies in health systems, youth support systems, workplace policies and social protection systems. Lastly, the COVID-19 crisis appears to already be widening existing inequalities, and this will increase the need for Adherents and stakeholders to focus on supporting the mental health of particular groups through integrated mental health, skills and work policy.

6.3.1. Digitalisation of mental health services may have been accelerated by the COVID-19 crisis

193. As discussed above in Section 5.3.1, digital mental health services – ranging from specialised services such as eCBT to lower-threshold services such as apps – were an area of rapid growth and expansion even from before the COVID-19 crisis, and the importance of leveraging data and digital technologies to achieve health objectives was widely acknowledged (OECD, 2019[43]). Since the onset of the COVID-19 pandemic, physical distancing measures – to limit the spread of the coronavirus – have resulted in an increased reliance on digital tools and teleconsultations to support individuals experiencing mental health conditions. In a survey by the WHO, 90% of high-income countries reported putting in place telemedicine arrangements to replace in-person consultations for mental health services, and more than 80% of high-income countries reported establishing helplines dedicated to mental health support (WHO, 2020[44]). Respondents to the follow-up questionnaire also cited several measures that had been taken to increase the capacity of mental health services to respond to the immediate needs of the population.

194. This enforced reliance on digital mental health services also appears likely to persist beyond the pandemic. The potential of digital health care and telemedicine has been shown to the population at large, and many providers and patients have found digital mental health services to be a viable alternative to in-person services. While the digital transition and digital tools are not mentioned explicitly in the Recommendation, it can help enable timely intervention and support for individuals with mental health issues as called for by the Recommendation by increasing access and reducing costs associated with providing mental health care. This shows the flexibility of the Recommendation and its principles to adjust to the changing realities of our societies.

6.3.2. Disruptions caused to learning and working by the COVID-19 crisis will require an integrated mental health, skills and work policy response

195. Since the Recommendation goes beyond the health system, due consideration must also be given to how the COVID-19 crisis may affect the nature of education, employment and social protection, and the implications that this may have for the Recommendation. While discussing the wide-ranging effects of the crisis on the way we live, learn and work is beyond the scope of this report, there are a number of possible long-term changes worth further consideration. This includes the risk of long-term consequences arising from disruptions to learning and working as well as the longer-term implications of the COVID-19 crisis for employment prospects.

196. The major disruptions caused to learning and working will likely have long-term implications for integrated mental health, skills and work policies. Although the OECD unemployment rate has gradually declined from the early stages of the crisis, at 6.9% in December 2020, it still remained 1.7 percentage points above pre-crisis levels in February 2020 (OECD, 2021[45]). Millions of jobs have already been lost during the crisis, and millions more remain on job retention schemes. There is ample evidence that losing

a job can contribute to mental health deterioration and longer durations of unemployment are associated with a higher burden of disease and mental distress (Herbig, Dragano and Angerer, 2013[46]). Moreover, given the risk of increased joblessness lasting well beyond the pandemic, the emphasis of the Recommendation on expanding access to individualised and integrated mental health and employment support in welfare policies and the social protection system will thus be particularly important in the years ahead.

197. Similarly, while for some students, disruptions to learning may only have been temporary, there may be longer-term consequences such as disengagement from school, which in turn, could threaten progress made in many countries in reducing the rate of early school leaving as called for by the Recommendation. This risk may be even greater for young people in higher education institutions who have often had to continue learning remotely, even while in-person teaching for primary and secondary students resumed in some Adherents (OECD, 2020[47]). In this context, the Recommendation's emphasis on ensuring a smooth transition into further education and the labour market will remain pertinent in the years ahead. This is even more the case as young people have seen disproportionate rises in unemployment, with youth unemployment remaining high at 14.4% as of December 2020 (OECD, 2021[45]).

6.3.3. The COVID-19 crisis is changing the way we work and learn

198. The COVID-19 crisis is also driving change in the way we work and learn. Stimulated by countries and employers putting in place facilitating measures, around 39% of workers suddenly shifted to teleworking. While an unprecedented number of workers were teleworking for the first time, in many cases, employees have been able to adapt rapidly, breaking perceptions about the ineffectiveness of teleworking. While evidence dating from before the COVID-19 crisis on the mental health impacts of teleworking as compared to in-person work is mixed, concerns have been raised about evidence of longer and more irregular working hours in some countries, as well as the mental health challenges associated with the blurring of boundaries between work and home (OECD[42]).

199. Teleworking also looks likely to last beyond the COVID-19 crisis and become a defining feature of the future of work. Surveys across a number of OECD countries indicate that workers, executives, and employers in some countries would like to employ hybrid working arrangements that combine teleworking with in-person work beyond the pandemic (OECD[42]). There remains scope for further analysis for the implications of increased teleworking for mental health, and the changing organisation of work resulting from the broader digital transformation. Similarly, the shift to remote learning may have opened up long-term opportunities and consequences for how learning and studying is organised, which may have implications for mental health policy in schools, universities and other educational institutions (OECD, 2020[48]). This may include, for example, changes in the nature of risks associated with mental health, such as a rise in cyberbullying.

200. One concern to note from the rise of teleworking and remote learning, and as countries apply key principles from the Recommendation, is that the digital transformation will also not benefit or affect everyone equally. It is worth noting, for example, that a majority of jobs still "cannot, or can hardly be performed from home", and only around one-third of jobs can be done from home under normal conditions with significant differences between industries (OECD, 2020[49]). Moreover, data from the OECD Survey of Adult Skills (PIAAC) shows that on average in 28 Adherents, more than 50% of the adult population can only carry out basic ICT skills or have no ICT skills at all (OECD, 2015[50]).

6.3.4. The COVID-19 crisis is widening inequalities in mental health, skills, and labour market outcomes

201. Many Respondents to the follow-up questionnaire also raised concerns over the risk of widening of existing inequalities and the need to focus policy attention on supporting the mental health of

disadvantaged groups, and those disproportionately affected by the crisis. These comments related not only to the health system, but also to social, labour market and educational outcomes, while concerns were also raised over the compounding and overlapping of inequalities. The importance of accounting for the unequal burden of the crisis is already evident from the particularly high prevalence of mental health issues among certain groups such as, but not limited to, young people, low-income households, and individuals with prior experience of mental health conditions.

202. In this context, an integrated approach to mental health as called for by this Recommendation may gain extra significance, as inequalities in mental health outcomes often overlap or are exacerbated by other inequalities in skills and labour market outcomes. For example, as outlined in the OECD Employment Outlook, low-income workers have not only reported poorer mental health outcomes, they were also twice as likely to have stopped working in April 2020 in comparison to their higher-income counterparts (OECD, 2020[51]). As the Recommendation recognises, it is vital that social protection systems provide support to the many low-income workers who have lost their jobs not only through employment support and training, but where appropriate, integrated mental health support.

203. There are similar concerns in skills and youth support systems. While schools have reopened across many Adherents, the long-term effects of months of disrupted learning cannot be dismissed. There are concerns that many students may have disengaged or have been unable to continue to learn remotely, while access to mental health services through schools and educational institutions has been restricted. These effects are disproportionately falling upon students from less affluent and disadvantaged families. In such a context, the role of schools, teachers and families in promoting mental health as called for by the Recommendation will become even more important, not only through identifying mental health issues but also through supporting students to continue their studies and limit increases in early school leaving.

204. Moreover, the COVID-19 crisis has been a timely reminder of the need to focus on the gender dimensions of integrated mental health policy. Even from before the crisis, as covered in the indicators in Annex B, working-age women were 45% more likely than men to report mental health conditions. Initial evidence after one year into the crisis suggests that there may be disparities in how the mental health of men and women have been affected, with corresponding long-term consequences. As the Recommendation recognises, mental health conditions are not evenly distributed between men and women, and subsequently, mental health policy responses will have to take a gender lens.

205. Many Adherents already focused on promoting the mental health of disadvantaged groups and preventing the widening of existing inequalities in mental health from before the crisis. The policy questionnaire responses provided many examples of such initiatives in practice. In Finland, the PALOMA project is developing models to support the mental health of refugees, while in Ireland guidelines have been developed to support the mental health of the LGBTI+ community. In New Zealand, promoting the mental health of the Māori population has been a priority for the government since 2005. The COVID-19 crisis may reinforce the need for both Adherents and the Secretariat to examine more closely inequalities in social, employment, education and health outcomes and the importance of integrated mental health, skills and work policies in ensuring these gaps are not further exacerbated in the years ahead.

6.4. Next steps

206. This draft report on the implementation, dissemination and continued relevance of the Recommendation shows that its principles remain relevant and up to date, and even more acute amidst the COVID-19 crisis, in view of the sharp (at least temporary) increase across the population in a range of mental health concerns. Nevertheless, challenges remain in the implementation of the Recommendation and increasing the awareness about the Recommendation among relevant stakeholders. The draft report identifies a large number of good practices on integrated approaches in various policy fields that could be followed, and expanded upon, looking forward. While the Respondents consider that no further revision of

the Recommendation would seem warranted at this point, several areas for possible further action have been identified.

207. Adherents should consider:

- Using the Recommendation as an ongoing framework to assess progress in developing a fully integrated mental health, skills and work policy.
- Improving the dissemination of the Recommendation to all relevant stakeholders, and especially non-government organisations, including by producing translations in their domestic language and increasing the visibility of the Recommendation on their domestic platforms.
- Undergoing country reviews of their integrated mental health, skills and work policies, tailored to the needs of the Adherent, which would use the Recommendation as a framework.

208. To support Adherents' efforts, the Secretariat could (subject to available resources):

- Develop other tools or toolkits that may support Adherents in the implementation or dissemination of the Recommendation.
- Strengthen dissemination efforts including through flyers that are shared with non-Adherents and relevant stakeholders, and especially non-governmental organisations.
- Organise workshops on a number of issues covered in the Recommendation, at national or international level, to share good practices and facilitate its implementation (interested Adherents could volunteer to host such events).
- Improve and update the proposed outcome indicators presented in Annex B of this document continuously, nationally and internationally, to assess the impact of policy improvements.

209. It is also proposed that the ELSAC and the HC, in consultation with the EDPC, continue the monitoring process and report back to the Council in five years with an assessment of the implementation, dissemination and continued relevance of the Recommendation in line with the recommendations of the OECD-wide Standard-Setting Review (see C/MIN(2018)11, par. 44). This first report will provide a baseline with which to continue to compare the implementation processes in various Adherents over the coming years.

Annex B. Comparative indicators for integrated mental health, skills and work policy

Acknowledgement: The following indicators are based on data from national and international population surveys. Most data are available online or provided to the OECD by the European Union. Special thanks for the provision of national data go to the Ministry of Health in Israel; the Ministry of Health, Labour and Welfare in Japan; the Robert Koch Institute in Germany; Sciensano in Belgium; Statistics Netherlands; the National Statistical Institute in Spain; the Federal Statistical Office in Switzerland; and the National Center for Health Statistics in the United States.

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

Introduction

210. This Annex presents a series of indicators across 32 of 37 OECD countries on the mental health, skills and work outcomes for individuals experiencing mental health issues to supplement the report presented in Annex A. These indicators aim to convey the differences in labour market and well-being outcomes between these groups. The choice of indicators and time span partly reflects data constraints. However, each section aims to present some of the most recent data and highlight topics that may be of practical use to policymakers.

211. Throughout this annex, an indicator of mental distress serves as a proxy for those with a mental health condition. In theory, when measuring the presence of a mental health condition, an interviewer could simply ask if a person is experiencing a given condition. However, in practice, this determination is difficult to achieve using a standardised questionnaire. Respondents may be hesitant to share information that they consider stigmatising (Clement et al., 2015[52]; Corrigan, Druss and Perlick, 2014[53]), or may not be aware of their mental health condition. An alternative approach would focus on those diagnosed with a mental health condition. This approach is problematic for the same reasons but also because not all people experiencing mental health conditions seek help, or even a diagnosis. Many people with common mental health conditions attempt to address their issues themselves (Mojtabai et al., 2011[54]). Therefore, restricting the scope to those with a diagnosed mental health condition will not be adequate.

212. In lieu of a direct measure of the presence of a mental health condition, this section uses indirect measures of mental health status (known as "mental health instruments") commonly utilised in population surveys. It thereby follows previous OECD analysis (OECD, 2012[1]) and assumes that in each country examined, irrespective of the year, a constant 20% of the working-age population has some form of mental health condition, whether they have been diagnosed with that condition or not. This assumption is in broad agreement with epidemiological evidence, which suggests that up to 30% of the adult population have had a mental disorder over any 12-month period and around 20%, or around one in five, at any point in time (Kessler et al., 2005[55]; Alonso et al., 2004[56]; Steel et al., 2014[57]). This approach also reflects the notion of mental health being a continuum, with poor mental health at one end and flourishing mental health on the other, rather than the absence or presence of a mental health condition.

213. This methodology has strengths and drawbacks. Core to the current analysis, it permits some form of cross-country and cross-survey comparisons. By taking the respondents with the bottom quintile of scores over a battery of questions on their mental health status, this approach abstracts away from the specification of the mental health instrument included in any given survey. For example, many European OECD countries have contributed to the European Health Interview Survey (EHIS), which for most countries employs an 8-question version of the Patient Health Questionnaire (PHQ-8), while non-European countries (and some European ones) include a series of mental health questions that are survey specific.[12] Results from these various surveys are better comparable using this relative mental health indicator.

214. A downside of this proxy approach is that there is no certainty that a person classed as having a mental health condition actually has one. To some extent, this is an intended feature, as the mental health indicator aims to capture also those who have a mental health condition, but have not sought professional help (including those who are unaware of their mental health condition). However, it is possible that there are some differences in mental health prevalence across countries, which the indicator assumes away. The same limitation applies for comparisons over time within countries. In considering this limitation, the set of indicators below does not focus on differences in prevalence across countries or over time, and instead presents outcomes that could be useful to policymakers. It thus also avoids discussing potentially large cross-country cultural differences in the levels of awareness, stigma and discrimination.

[12] A common cut-point for the PHQ-8 is a score of ten within the United States (Kroenke et al., 2009[67]).

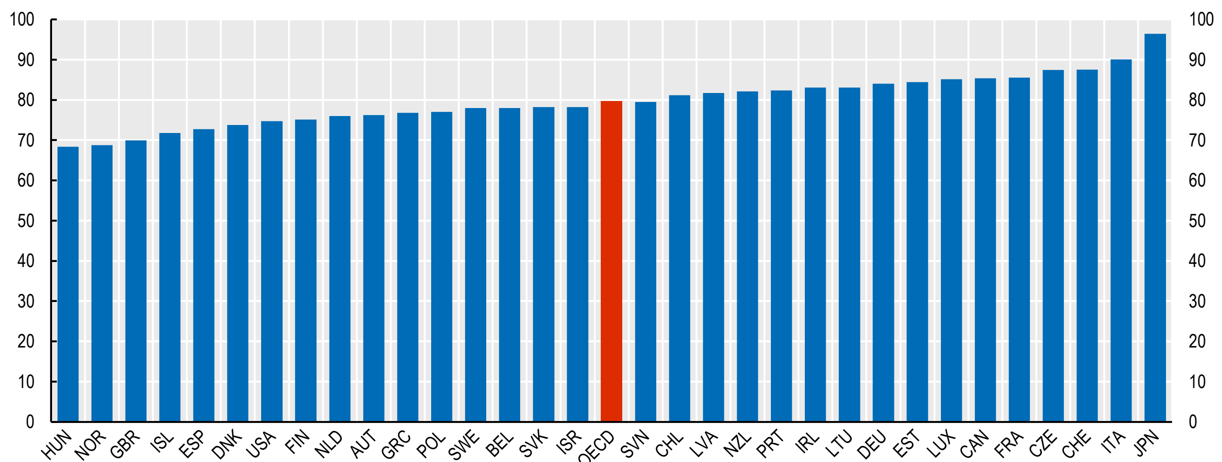
Employment outcomes

215. In every OECD country examined, people with some form of mental health issue (that is, those scoring in the lowest 20% in a battery of questions about respondents' mental health status) had lower and sometimes much lower employment rates than those not reporting signs of a mental health issue. Figure A B.1 depicts the ratio of the employment rates for these two groups. Values below 100 indicate lower employment rates for people with mental health conditions than those without.[13]

216. On average, the employment rate for persons with a mental health condition was 20% less than for those without. The mental health employment gap ranges from over 30% for Hungary, Norway, and the United Kingdom, to 10% in Italy and only 3.6% in Japan. For those with more severe mental health issues – that is, those with a mental health score in the lowest 5% of respondents – the gap is even larger, averaging almost 38% and ranging from 55% in the United States to 9% in Japan (not shown in the figure).

Figure A B.1. The employment gap between persons with and without a mental health condition is large

Employment rate ratio between persons with and without a mental health condition, mid-2010s[1]



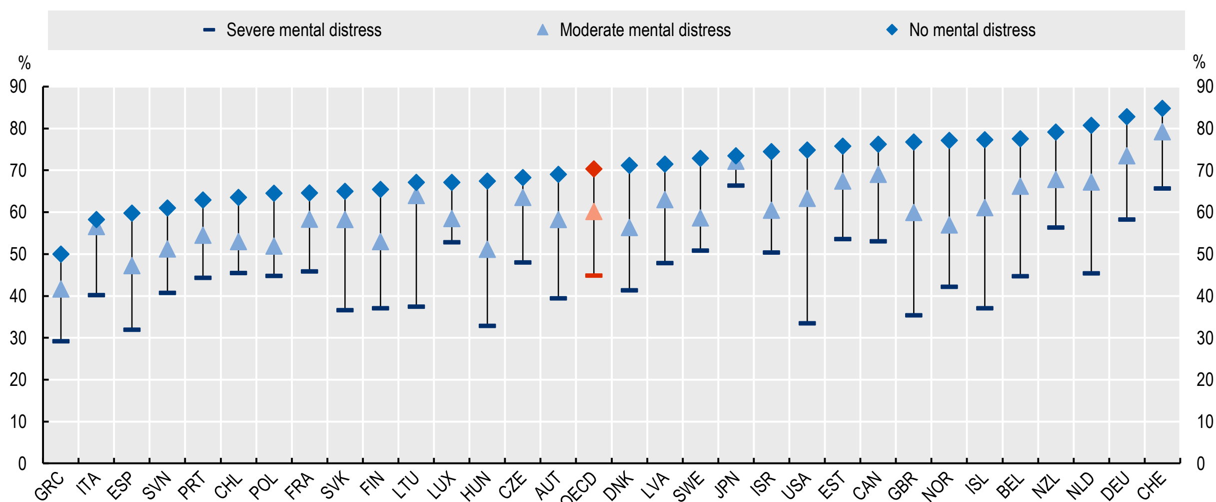
Note: OECD average is the unweighted average of the depicted countries. A value of 100 indicates that people with mental health conditions are equally likely to be working as persons without mental health conditions. Individuals with a mental health condition have provided survey responses to a series of mental health questions that place them in the bottom quintile of respondents.
1. The figure presents data between 2012 and 2016. The relevant year for each country is outlined in Table A B.1..
Source: EHIS-2, CCHS, SHS (2012), GEDA, INHIS-3, GSS, NHIS (2013), CSLC, ENCAVI. See detailed data source descriptions in Table A B.1.

217. This indicator is useful as it provides a simple indication of the relative employment outcomes of these groups. As transitions to unemployment negatively affect mental health (Paul and Moser, 2009[58]; Murphy and Athanasou, 1999[59]), it is unlikely that any country will ever achieve a value of 100 (indicating equal employment outcomes). However, countries can close the employment gap through various measures, by engaging unemployed workers to address their mental health condition, improving the job prospects of people with a mental health condition, adapting the workplace to encourage workers to stay in employment where appropriate, and enhancing the early identification and treatment of mental health conditions (OECD, 2015[2]). Successful policy measures in each of these domains would improve the indicator shown in Figure A B.1, pushing it toward 100.

[13] The indicator does not distinguish between full and part-time employment. Part-time work could be a useful tool for people with mental distress by allowing them to continue in employment or to return to work (see Figure A B.7).

Figure A B.2. Across the OECD, one in two persons with a mental health condition are in work

Employed people aged 15-64 over total population aged 15-64, by mental health status, mid-2010s[1]



Note: OECD average is the unweighted average of the depicted countries. Individuals with mental distress have provided survey responses to a series of mental health questions that place them in the bottom quintile of respondents. Ireland data excluded due to data quality concerns.
1. The figure presents data between 2012 and 2016. The relevant year for each country is outlined in Table A B.1.
Source: EHIS-2, CCHS, SHS (2012), GEDA, INHIS-3, GSS, NHIS (2013), CSLC, ENCAVI. See detailed data source descriptions in Table A B.1.

218. Presenting employment rates as a ratio controls for overall labour market context and the business cycle. Figure A B.2 presents the underlying raw employment rates by severity of the mental health condition, which shows that the ratio is only part of the story. For example, both Italy and Switzerland have some of the largest ratios in Figure A B.1, implying that those with a mental health condition in those countries have more similar employment outcomes as those without. However, Figure A B.2 shows that these high ratios stem from two different realities. Switzerland has high overall employment rates, while employment rates in Italy are relatively low, regardless of the mental health status. More generally, across the OECD, there is a strong correlation (0.89) between the employment rates of those with and without a mental health condition.

219. That these two different scenarios for Switzerland and Italy result in similar ratios suggest similar outcomes, but different potential policy solutions. Italy could likely yield greater gains by improving the overall labour market situation than focusing on those facing a mental health condition, as broad labour market measures will likely benefit both groups. Conversely, Switzerland may find greater improvements in the well-being of people with a mental health condition by implementing targeted interventions for people in need.

Definition and measurement

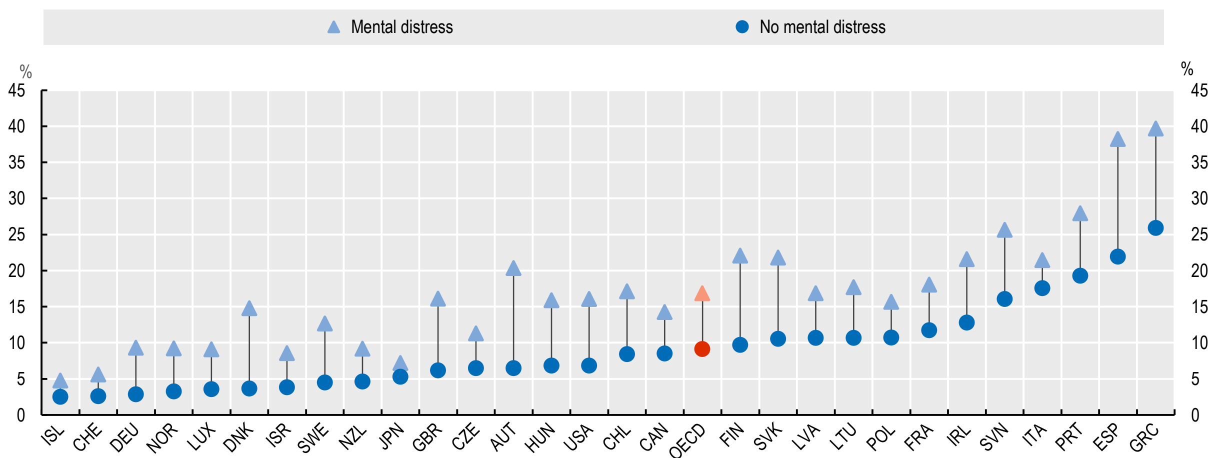
Figure A B.1 presents a ratio of employment rates. The employment rate is itself a ratio of the working-age population as a whole and the working-age population in employment. The ratio in Figure A B.1 compares those with and without a mental health condition. Values below 100 indicate that the employment rate for those with a mental health condition is lower than for those without. Figure A B.2 presents the underlying employment ratios that constitute Figure A B.1. The underlying employment rates are derived from health surveys, and may differ from official employment rates as computed from labour force surveys.

Labour force outcomes

220. Many people reporting a mental health condition want jobs, but cannot find them. This is evident in Figure A B.3, which shows that unemployment is much more prevalent amongst those who have a mental health condition. Across OECD countries, the unemployment rate was, on average, 85% (7.7 percentage points) higher for people reporting a mental health condition than for those not reporting such condition. While the mere act of being unemployed can be very distressing, this difference in unemployment rates also suggests either that people with poorer mental health are looking for jobs without success, or that they are transitioning more frequently into and out of work, or both.

Figure A B.3. Persons reporting mental health conditions are significantly more likely to be unemployed

Unemployed working-age individuals as a share of the labour force, by mental health status, mid-2010s[1]



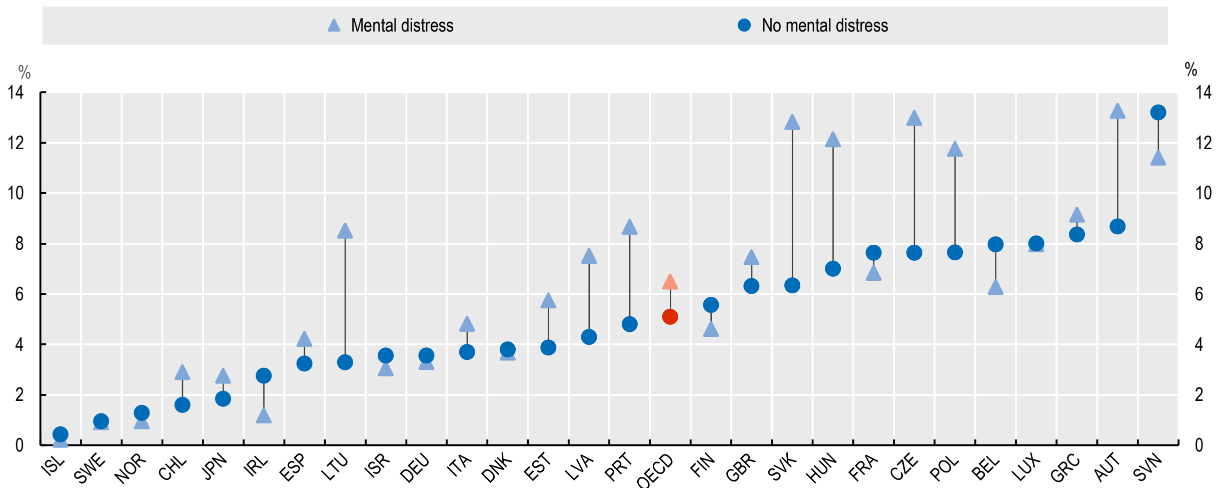
Note: OECD average is the unweighted average of the depicted countries. Individuals with mental distress have provided survey responses to a series of mental health questions that place them in the bottom quintile of respondents. Data for Estonia is excluded due to data quality issues.
1. The figure presents data between 2012 and 2016. The relevant year for each country is outlined in Table A B.1.
Source: EHIS-2, CCHS, SHS (2012), GEDA, INHIS-3, GSS, NHIS (2013), CSLC, ENCAVI. See detailed data source descriptions in Table A B.1.

221. The consistency of this pattern across countries highlights the link between a higher incidence of mental health conditions and reduced well-being within the unemployed found in many studies (Clark, 2003[60]; Strandh et al., 2014[61]; Brand, 2015[62]). Moving from employment to unemployment can be a stressful experience for many individuals, and can lead to lower life satisfaction, doubt, and loss of self-esteem, and longer durations of unemployment are associated with a higher burden of disease and mental distress (Herbig, Dragano and Angerer, 2013[46]). Indeed, unemployment can leave lasting negative mental health effects, many of which may even outlast the unemployment spell itself (Knabe and Ratzel, 2011[63]).

222. Despite the scarring effects that periods of unemployment have on mental health, the variation apparent in Figure A B.3 suggests that policy can play a role in lessening the impact. For example, Germany and Switzerland have similar levels of unemployment among persons without mental health conditions, while the unemployment rate for those with a mental health condition is higher in Germany than in Switzerland. Similar comparisons are possible with Israel and Denmark, New Zealand and Sweden, the Czech Republic and the United Kingdom, to name a few. Further in-depth comparisons of the demographic and policy landscapes between these pairs of countries could uncover insights into effective policies to limit the mental distress that stems from unemployment.

Figure A B.4. In some countries, persons reporting mental health conditions tend to retire earlier

Share of the working-age population (aged 15-64) in retirement, by mental health status, mid-2010s[1]



Note: OECD average is the unweighted average of the depicted countries. Individuals with mental distress have provided survey responses to a series of mental health questions that place them in the bottom quintile of respondents.
1. The figure presents data between 2012 and 2016. The relevant year for each country is outlined in Table A B.1.
Source: EHIS-2, GEDA, INHIS-3, CSLC, ENCAVI. See detailed data source descriptions in Table A B.1.

223. In some cases, working age individuals opt to take early retirement rather than remain in work or search for a job in unemployment. The share of those taking early retirement varies considerably across OECD countries but, for most countries, does not differ greatly empirically by the presence of a mental health condition (Figure A B.4). On average, 5.1% of those not reporting a mental health condition have taken early retirement, compared with 6.6% of those reporting such conditions. However, some countries show much greater differences between those with and without mental health conditions, particularly those from central Europe and the Baltics. For example, early retirement is more likely for those with mental health conditions in Austria, the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Slovakia, Poland and (a geographical exception) Portugal. Within these countries, people with mental health conditions are more than 80% more likely to take early retirement than those not reporting mental health conditions.

224. Research confirms that premature exits from the labour market via early retirement can often be driven by poor (mental) health (Biffl and Leoni, 2009[64]; Olesen, Butterworth and Rodgers, 2012[65]; OECD, 2015[2]). Other evidence suggests that voluntary early retirement can be associated with improved mental health (Melzer, Buxton and Villamil, 2004[66]), implying that much of the incidence of early retirement in those with mental health conditions was likely motivated by involuntary exits from work.

Definition and measurement

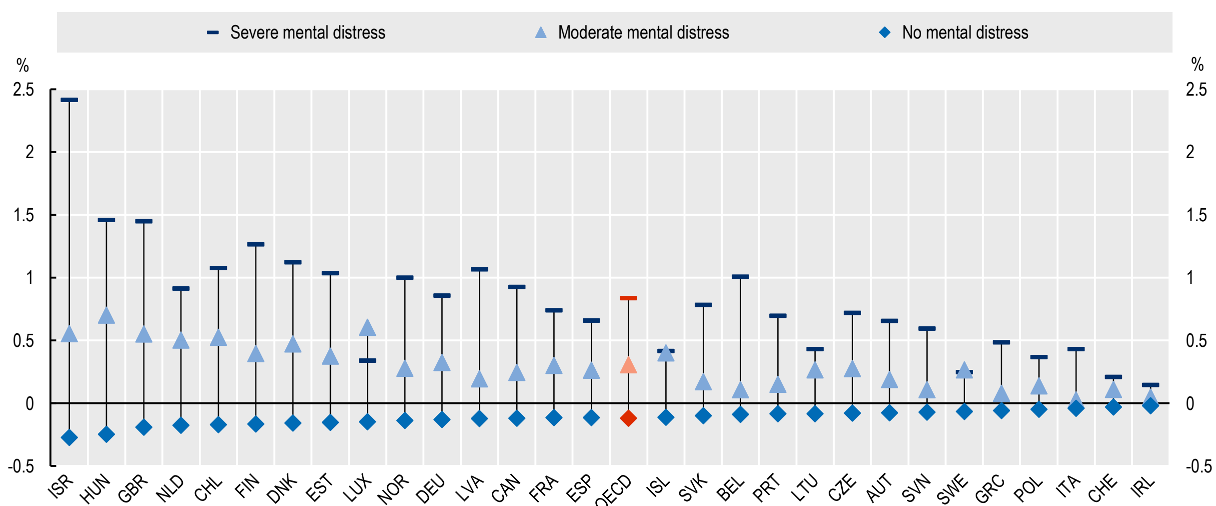
To facilitate the comparison of labour market outcomes by mental health status, unemployment rates shown in Figure A B.3 have been calculated from health surveys. These unemployment rates may not match those commonly reported in labour force surveys. In Figure A B.4, respondents who have taken “early retirement” are those who have retired before age 65. In practice, the normal retirement age varies across countries, and occasionally by gender. For example, retirement in France is possible for some workers aged 55, while the normal retirement age is 63.3. Likewise, the retirement age is 62.2 years in the Slovak Republic, and 62 years for men and 61.7 years for women in Slovenia.

Income and earnings

225. Individuals with mental health conditions are more likely to live in lower-income households than those without such conditions. On average across OECD countries, those with moderate mental health conditions were 31% more likely to live in households in the lowest income quintile than expected if evenly distributed amongst the income distribution (Figure A B.5). Comparatively, those with no mental health conditions were 12% less likely to live in low-income households. People reporting severe mental health conditions fare far worst: on average, they are 83% more likely than expected to live in low-income households. They are almost 2.5 times more likely than expected to be in low-income households in Israel and more than twice as likely in Chile, Denmark, Finland, Hungary, Latvia, and the United Kingdom.

Figure A B.5. Persons reporting mental health conditions are more, and in some countries much more, likely to live in lower income households

Share with equivalised income falling in the lowest household income quintile, by mental health status, mid-2010s[1]



Note: OECD average is the unweighted average of the depicted countries. Individuals with mental distress have provided survey responses to a series of mental health questions that place them in the bottom quintile of respondents. Income data available in Israel does not provide quintiles, but rather broad groups of earnings. Income deciles for Canada are not equivalised. Values above zero indicate an over-representation of a group within the lowest earnings quintile.

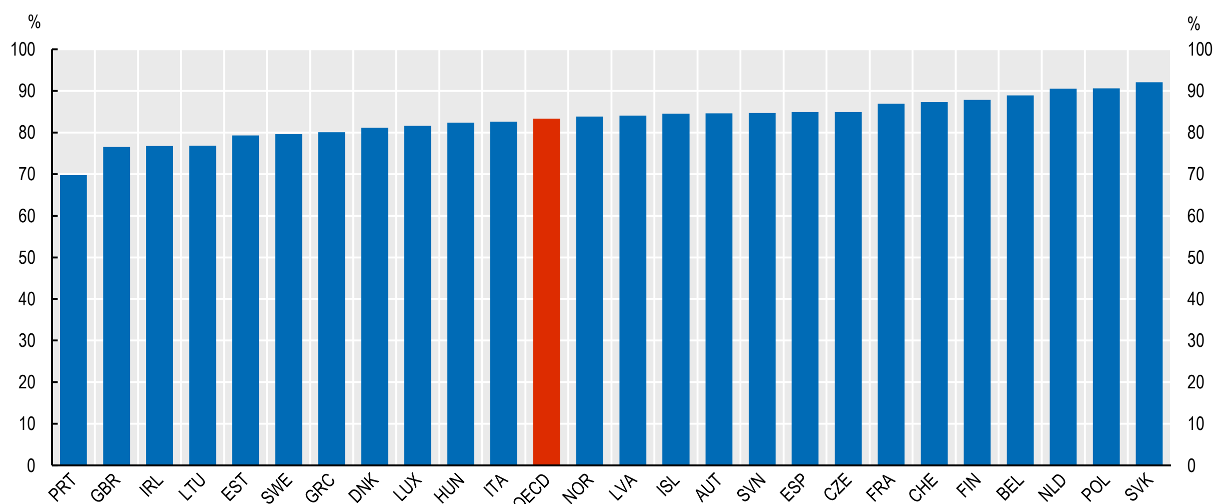
1. The figure presents data between 2012 and 2016. The relevant year for each country is outlined in Table A B.1.

Source: EHIS-2, CCHS, SHS (2012), GEDA, ENCAVI, INHIS-3. See detailed data source descriptions in Table A B.1.

226. Examining individual wages directly, the same pattern is evident: people with mental health conditions receive lower wages than those without. Figure A B.6 presents a comparison of full-time wages between those with and without mental health conditions for a subset of European OECD countries, for which such data is available. Values below 100 indicate that workers with mental health conditions earn less than those without, which was the case in all countries examined. On average across all countries, workers with mental health conditions were earning 83% of workers without mental health conditions. For example, in Portugal, workers reporting a mental health condition earned about 70% of the wage of their peers without mental health conditions, while the difference between the two groups was smaller in the Netherlands, Poland, and Slovakia (with a wage gap around 90%). A more detailed analysis of the worker characteristics could shed more light on the nature of these differences, and explore how outcomes differ within further refined groups, such as by age, gender, education and occupation.

Figure A B.6. Persons with mental distress have lower wages than those without mental distress

Average gross wage for full-time workers with over those without a mental health condition, 2013



Note: OECD average is the unweighted average of the depicted countries. Individuals with mental health conditions have provided survey responses to a series of mental health questions that place them in the bottom quintile of respondents. Due to differences in the reference period for reporting income and mental health, observations were limited to those full-time workers who have not changed jobs during the past year. Data for Denmark, Finland, Iceland, Norway, Sweden, and Lithuania include all full-time workers, as discriminating variables are not available.
Source: EU-SILC 2013 module on well-being. See detailed data source descriptions in Table A B.1.

227. While it is likely that simply having a low income, or being a member of a low-income household, is mentally distressing, these variations in the income and earnings distribution of individuals by mental health status suggest that countries have policy tools at their disposal that can help alleviate the distress associated with low incomes. One policy tool is the encouragement of employment amongst those with mental health conditions. There is a moderate correlation (0.5) between the employment gap between people with and without mental health conditions and their concentration within the lowest income quintile. This suggests that efforts to improve employment can also help lift those people out of poverty.

Definition and measurement

Figure A B.5 presents the ratio of the total share of survey respondents in the lowest income quintile to the share of the groups by mental health status in the lowest quintile (minus 1). Values above zero indicate an over-representation of a particular sub-group compared to an even distribution of people across the income quintiles. Figure A B.5 uses equivalised household disposable income: total household earnings plus investment income and social benefits, less income taxes and social contributions, divided by a factor to equate different-sized households. Households with more members have additional needs, though this relationship is not perfectly proportional. Many surveys, including the EHIS, adjust household disposable income using the so-called *OECD-modified equivalence scale*, which divides total household income by the sum of the weights assigned to each household member (weight 1 for the household head, 0.5 for their spouse, and 0.3 for each dependent child). Other data, including the data for Chile, divide household income by the square root of the household size (this is also the method used in all recent OECD publications on income distribution and poverty). The income measure used in Figure A B.6 is the gross employee income (that is, before taxes and transfers) for those workers who have not changed jobs in the past year and who currently work full-time hours.

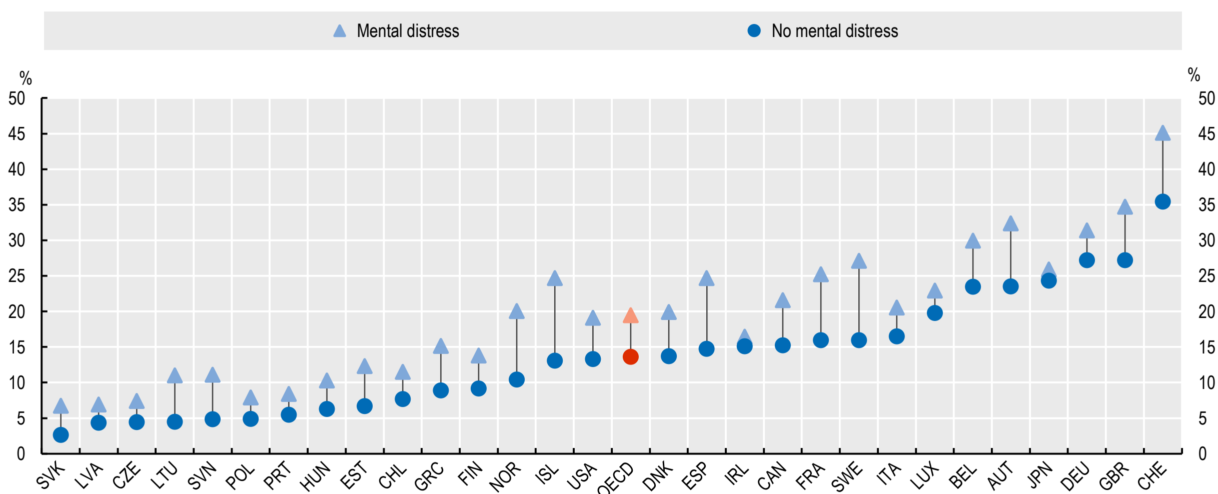
Work arrangements

228. There are some, but rather minor, differences in the work arrangements between people with and without mental health conditions. Figure A B.7 presents the share of dependent employment (that is, employees) that works part-time. In each country, those with mental health conditions were more likely to work part-time, though this difference was minimal in some countries, notably in Ireland, Latvia, the Czech Republic, Poland, Hungary, and Luxembourg. On average 19.5% of workers with mental health conditions worked part-time hours, compared with 13.6% of those without such conditions. Within workers with mental health conditions, the share working part-time ranged from 6.7% in Slovakia to 45.1% in Switzerland.

229. A high share of workers with mental health conditions working part-time is not necessarily an undesirable outcome. While many of these workers could possibly be involuntary part-time workers, who cannot find full-time jobs, another subset of part-time workers may be using reduced hours to balance the demands of a mental health condition. For those for whom this is the case, access to flexible hours or work schemes could be an essential means of managing their condition while remaining attached to the labour market. Some research suggests that part-time sick leave schemes in Sweden and Norway lead to positive outcomes for workers with mental health conditions (Andrén, 2011[67]; Markussen, Mykletun and Roed, 2010[68]), though other work examining a similar scheme in Denmark suggests these positive effects disappear after controlling for unobserved factors (Høgelund and Holm, 2011[69]). More research could clarify the value of part-time work as a management strategy for those with mental health conditions.

Figure A B.7. Persons with mental health conditions are more likely everywhere to work part-time hours

Share of dependent employment that works part-time hours, by mental health status, mid-2010s[1]



Note: OECD average is the unweighted average of the depicted countries. Individuals with mental distress have provided survey responses to a series of mental health questions that place them in the bottom quintile of respondents. Part-time work classifications follow national definitions.
1. The figure presents data between 2012 and 2016. The relevant year for each country is outlined in Table A B.1.
Source: EHIS-2, CCHS, SHS (2012), GEDA, ENCAVI, NHIS (2013), CSLC. See detailed data source descriptions in Table A B.1.

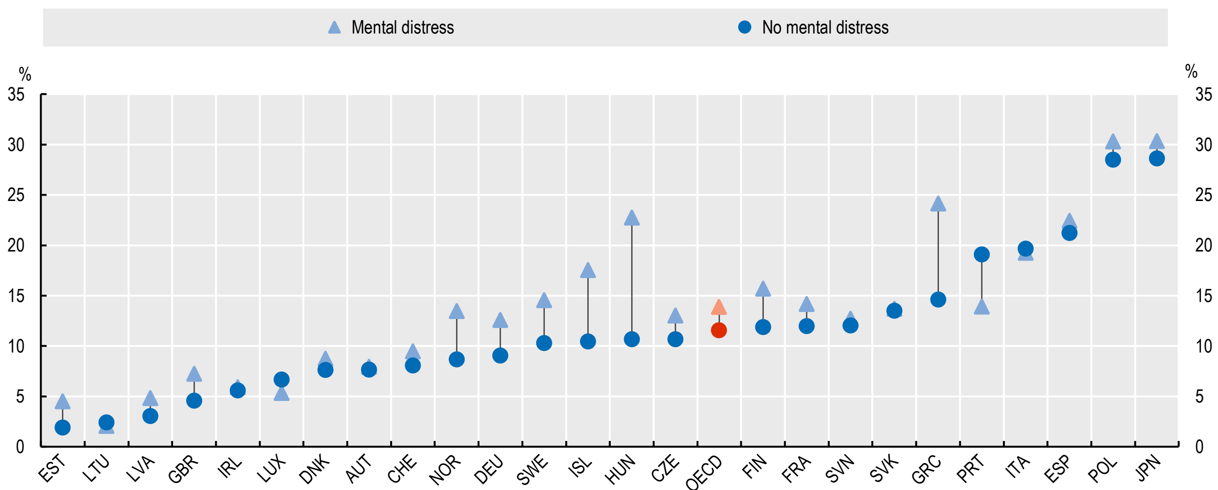
230. Separately, and maybe counterintuitively, there is a less clear relationship between temporary contracts and mental health status. Figure A B.8 presents the share of workers that report mental health issues who are on temporary contracts compared with those without mental health issues. For most countries, there is a negligible difference between these two groups. While on average, those with mental health issues are slightly more likely to work on temporary contracts – 13.9%, versus 11.5% for those

without mental health issues – much of this difference stems from differences in a few countries, notably Hungary, Greece, and Iceland, and to a lesser extent Norway, Germany, and Sweden.

231. In Hungary, more than a fifth (22.8%) of people with mental health issues are temporary contract workers, versus only 10.7% of those without such issues. Likewise, in Greece, one quarter (24.1%) of workers with mental health conditions hold temporary contracts, while 14.6% of workers without conditions do. The differences in these countries, in light of the lack of difference in most other OECD countries, suggests that cultural work practices or policy regimes in these countries may favour temporary contracts for those with mental health conditions over other workers. For instance, in employment protection legislation regulating the eligible use of temporary contracts, the maximum successive duration and allowable number of successive renewals varies across OECD countries. In Hungary and Greece, there are no restrictions on the usage of fixed-term contracts, while in countries such as Italy, Luxembourg and Lithuania fixed-term contracts are primarily only allowed when replacing temporarily absent workers or when there is a clear time-limited need (OECD, 2020[70]).

Figure A B.8. In most countries, temporary contracts do not appear linked to mental health status

Share of dependent employment that holds temporary employment contracts, by mental health status, mid-2010s[1]



Note: OECD average is the unweighted average of the depicted countries. Individuals with mental distress have provided survey responses to a series of mental health questions that place them in the bottom quintile of respondents.
1. The figure presents data between 2012 and 2016. The relevant year for each country is outlined in Table A B.1.
Source: EHIS-2, SHS (2012), GEDA, CSLC. See detailed data source descriptions in Table A B.1.

Definition and measurement

Figure A B.7 presents part-time work according to nationally chosen definitions. The OECD often uses an international definition, considering those who work less than 30 hours per week as “part-time” workers. However, the definition of part-time work can vary across countries. For instance, this cut-off is 35 hours per week in Australia, Austria, Iceland, Japan, Sweden, and the United States, while it is 36 hours in Hungary and Turkey, and 37 hours in Norway. Workers on temporary contracts shown in Figure A B.8 have self-identified as having employment contracts of limited duration. This may include arrangements such as fixed-term contracts, internships, apprenticeships, or temporary work-agency jobs.

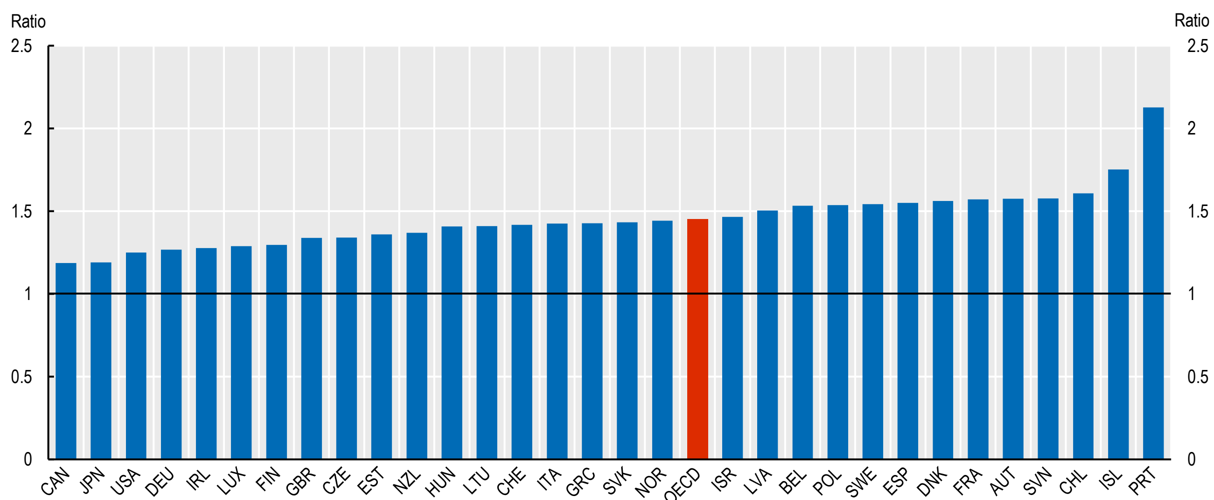
Gender and mental distress

232. Previous work examining a subset of OECD countries has shown that females have been overrepresented amongst those with mental health conditions (OECD, 2012[1]).This remains true when examining a larger set of OECD countries (Figure A B.9). On average, working-age females were 45% more likely to report mental health conditions than males of that age. This observation was common across all examined countries, although with some variation in magnitude. For instance, females were only 19% more likely to report mental health conditions than their male counterparts in Canada and Japan, but more than twice as likely (113%) in Portugal.

233. Though many studies have observed that females have a higher lifetime prevalence of many common mental health conditions, including depression and mood disorders, the cause of this difference is not well understood (Riecher-Rössler, 2017[71]; Kuehner, 2017[72]). Certainly, some of this is due to differences in self-reporting, as males have more negative stigmas against mental health care (Ojeda and Bergstresser, 2008[73]; Schnyder et al., 2017[74]; Corrigan, 2004[75]) and perceive themselves as having less of a need for care (Villatoro et al., 2018[76]). External factors also influence mental health status. For example, females are more likely to experience violence, gender discrimination, and gender inequality (Riecher-Rössler, 2017[71]). Rectifying these societal-level gender imbalances is already a priority for many OECD countries, and a by-product of these efforts could be improved mental health outcomes for females.

Figure A B.9. In all countries, a higher proportion of those reporting mental health conditions are female

Ratio of the share of those with mental health conditions, share female over share male, mid-2010s[1]



Note: OECD average is the unweighted average of the depicted countries. Individuals with mental health conditions have provided survey responses to a series of mental health questions that place them in the bottom quintile of respondents. Values below one indicate that a higher proportion of males report mental health conditions than females.
1. The figure presents data between 2012 and 2016. The relevant year for each country is outlined in Table A B.1.
Source: EHIS-2, CCHS, SHS (2012), GEDA, ENCAVI, INHIS-3, GSS, NHIS (2013), CSLC. See detailed data source descriptions in Table A B.1.

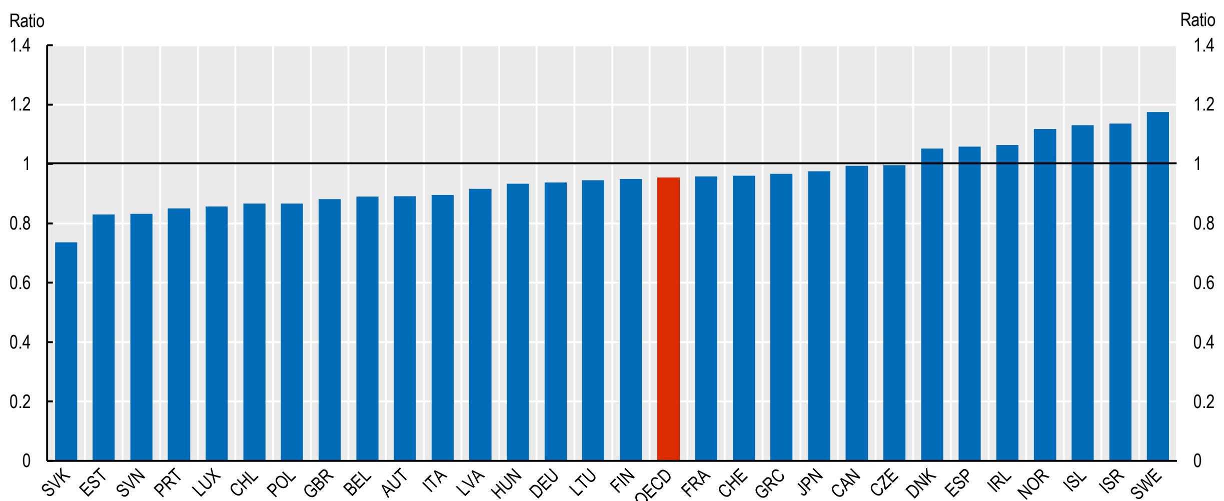
234. Despite a higher prevalence of mental health conditions for females, this does not necessarily translate into diminished employment outcomes relative to men with mental health conditions. Figure A B.10 presents an indicator comparing the employment gaps by mental health status for males and females. Values above one indicate that females have a larger gap in employment rates than males. On average, males were slightly more likely to have a larger gap in employment rates between those with and without mental health conditions. As an example, in Portugal, the employment rate was 52.5% and

59% for females with and without mental health conditions, respectively. For Portuguese males, comparable values were 50.1% and 66.2%. These values implied an employment rate ratio for Portuguese females of 0.89, and 0.76 for Portuguese males, indicating that males with mental health conditions have a larger employment gap than females (value of one=no gap). Of the 29 OECD countries examined, 21 exhibited similar patterns, though Denmark, Spain, Ireland, Norway, Iceland, Israel and Sweden exhibited the opposite.

235. A number of factors could explain the gender difference in employment gaps. Some evidence suggests that unemployment has a larger effect on the mental health of males than females (Artazcoz et al., 2004[77]) and that having a job is linked with lower anxiety disorder in males, but not in females (Plaisier et al., 2008[78]; Barnay, 2016[79]). Alternatively, the gender differences in perceptions toward mental health can discourage males from reporting a mental health condition unless it severely limits their quality of life (Ojeda and Bergstresser, 2008[73]; Villatoro et al., 2018[76]). Both of these explanations touch on subjective cultural norms and gender perspectives, such as males' self-perceived role as the main income provider, rather than objective differences in the prevalence of mental health conditions.

Figure A B.10. Employment rate gaps tend to be larger for males with mental health conditions

Ratio of share of employment rates of those with and without mental health conditions by gender, mid-2010s[1]



Note: OECD average is the unweighted average of the depicted countries. Individuals with mental health conditions have provided survey responses to a series of mental health questions that place them in the bottom quintile of respondents.
1. The figure presents data between 2012 and 2016. The relevant year for each country is outlined in Table A B.1.
Source: EHIS-2, CCHS, SHS (2012), GEDA, ENCAVI, INHIS-3, CSLC. See detailed data source descriptions in Table A B.1.

Definition and measurement

Figure A B.10 presents a ratio of ratios. The first is the ratio of employment rates between those with and without mental health conditions, similar to the ratio presented in Figure A B.1. The second is the ratio of these first ratios for both males and females. To interpret this indicator, values above one indicate that females have a larger gap in employment rates between those with and without mental health conditions than males. Similar to Figure A B.10, Figure A B.9 also displays a ratio. It compares the share of people who are experiencing mental health conditions, and compares the share of females experiencing conditions (the numerator) to the comparable value for males (the denominator).

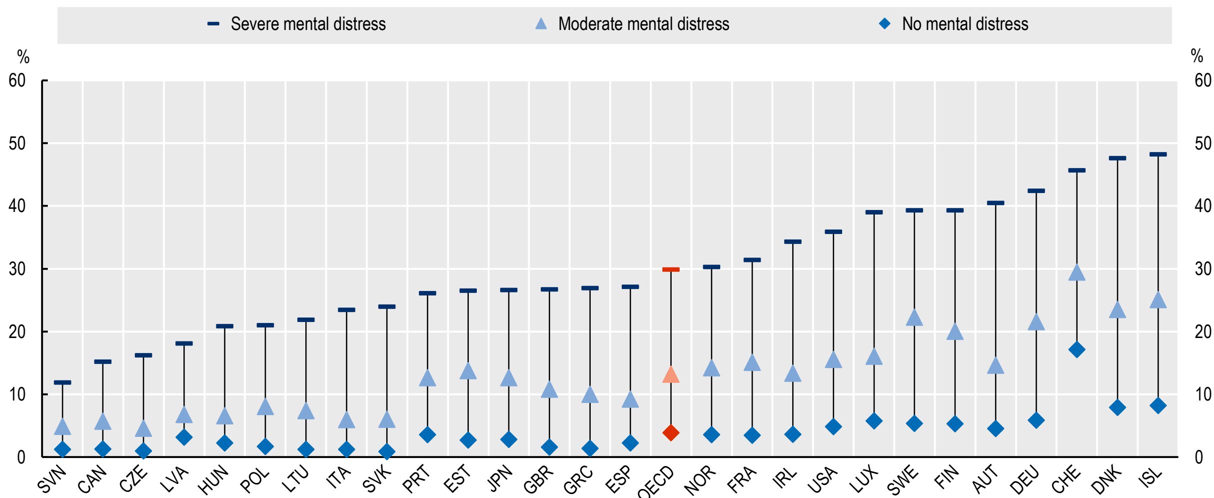
Health care used

236. Accessible health care for those who need it is essential to providing adequate care. Reflecting an increased need and use for mental health care services, across the OECD, people with mental health conditions are more likely to have visited a mental health professional over the past year (Figure A B.11). In the mid-2010s, on average, more than 13% of those with moderate mental health conditions had visited a mental health care professional, compared with approximately 4% of those with no condition. Among those with more severe mental health conditions, 30% sought the help of a mental health professional. The share of people seeking help varied across OECD countries, ranging from just under 5% in the Czech Republic to almost 30% in Switzerland for those with moderate mental health conditions. For people with severe conditions, the share seeking help ranged from almost 12% in Slovenia to just under 50% in Iceland.

237. While the share seeking help for those with severe mental health conditions is larger than either of the other two sub-groups, as expected, it also implies that the majority of people with mental health conditions did not visit a specialist in the past year, irrespective of the severity of their condition. There are many reasons why a person with mental health conditions may not seek help. Some people may not perceive a need for care, or would prefer to treat their issues themselves (Codony et al., 2009[80]; Thornicroft et al., 2017[81]; Van Beljouw et al., 2010[82]). Others may see treatment options as ineffective or have had negative experiences in the past with health care providers (Andrade et al., 2014[83]).

Figure A B.11. A minority of people with mental health conditions consult a mental health professional

Share of working-age individuals who consulted a psychologist, psychotherapist, or psychiatrist in the past 12 months, by severity of mental distress, mid-2010s[1]



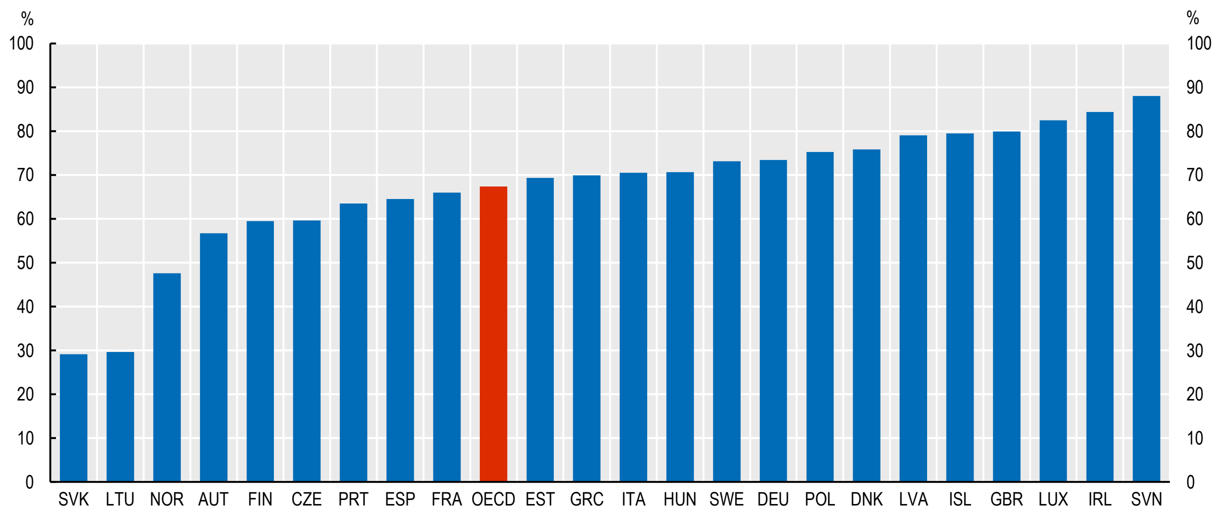
Note: OECD average is the unweighted average of the depicted countries. Individuals with mental distress have provided survey responses to a series of mental health questions that place them in the bottom quintile of respondents.
1. The figure presents data between 2012 and 2016. The relevant year for each country is outlined in Table A B.1..
Source: EHIS-2, CCHS, SHS (2012), GEDA, NHIS (2013), CSLC. See detailed data source descriptions in Table A B.1.

238. However, while many persons with mental health issues do not seek help or do not want help, there are many who want help but may have difficulty accessing it. As shown in Figure A B.12, many people with mental health conditions across Europe needed mental health care, but either could not afford it or experienced a delay in accessing it. On average across Europe, two in three of those with mental health conditions who expressed a need for care, had difficult accessing it. This was the case whether looking at those with only severe conditions (among them, 68.5% had difficulty accessing care) or when

restricting the analysis to those with mild-to-moderate mental health conditions (66.3%). Importantly, Figure A B.12 does not indicate a complete lack of access to health care, but rather that, at least once within the past 12 months, mental health care was difficult to access. Those with mental health conditions are more likely to require medical help, and so difficulties accessing medical care can fall more heavily on them than those without such conditions. A lack of access to medical care can lead to worse outcomes, as common mental health problems can evolve into more serious and debilitating problems if left untreated.

Figure A B.12. At least in Europe, mental health care can be difficult to access for various reasons

Share of people with mental health conditions that experienced difficulties accessing medical care (due to financial, waiting time or transportation constraints) given they expressed a need for care, mid-2010s[1]



Note: OECD average is the unweighted average of the depicted countries.
1. The figure presents data between 2012 and 2016. The relevant year for each country is outlined in Table A B.1.
Source: EHIS-2, GEDA. See detailed data source descriptions in Table A B.1.

239. Many health care authorities have highlighted the role of primary care providers in mental health care (Reiter, Dobmeyer and Hunter, 2018[84]). Primary care providers serve as gatekeepers to specialised mental health services, and improved training for these gatekeepers can facilitate greater access to mental health professionals for those who need it, and can also facilitate a move away from a binary view of mental health in order to improve prevention efforts (Williams, 2020[85]; OECD, 2015[2]).

Definition and measurement

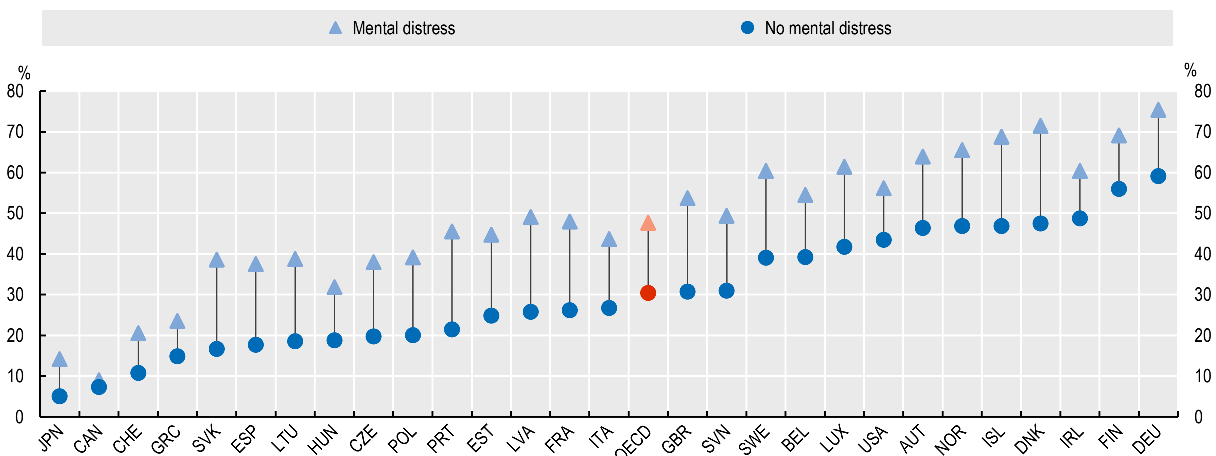
Figure A B.11. presents the share of people who have consulted a mental health professional while Figure A B.12. presents the share who have experienced difficulties accessing mental health care, given that they expressed a need for care. They responded either that they visited a mental health care professional in the past 12 months or that they had a need for care that was unmet. Values of 100 indicate that all people who wanted care received care. More concretely, respondents expressed a delay in receiving medical care “because the time needed to obtain an appointment was too long” or “due to distance or transport problems?” Respondents also indicated if they needed mental health care over the past 12 months, but could not afford it. Any affirmative indication indicated needed care that was unmet.

Sickness and absence from work

240. A key component of the societal burden of mental health is reduced productivity in the form of lost working hours (absenteeism) and reduced capacity while working (presenteeism). Mental health conditions drain workers of their motivation and capacity to work effectively. Consequently, workers with mental health conditions are more likely to report having missed work over the past 12 months than those without (Figure A B.13). On average, half (47.6%) of those with mental health conditions had been absent from work during the past year, compared with just under a third (30.4%) of those without such conditions. This is a common problem throughout the OECD, reflecting that many people with mental health conditions need more time away from work, as a means to manage or to address their underlying mental health issues.

Figure A B.13. Persons reporting mental health conditions are more likely to have missed workdays

Share of workers who have been absent from work at least once over the past 12 months, by mental health status, mid-2010s[1]



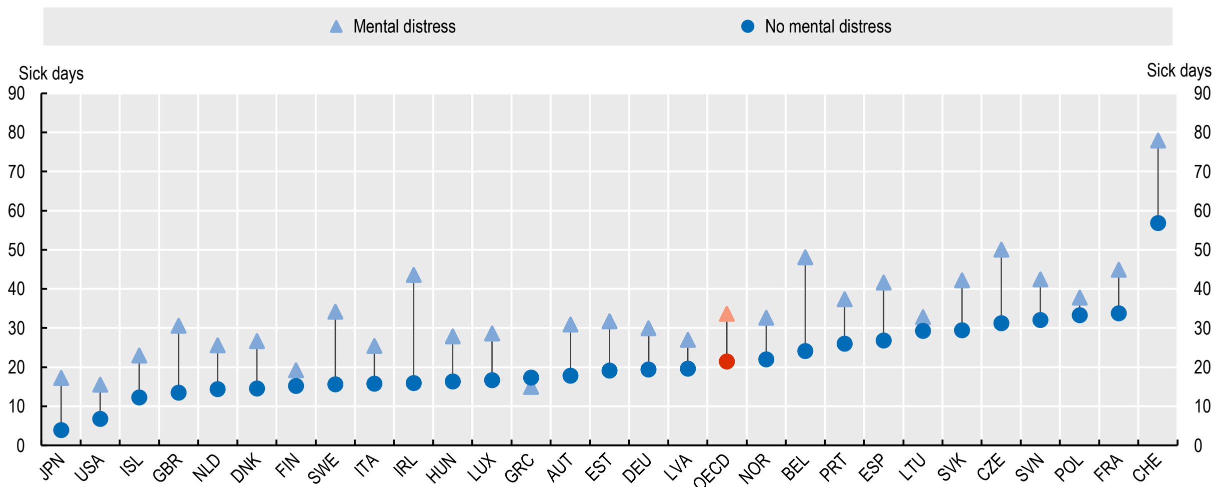
Note: OECD average is the unweighted average of the depicted countries. Data for Japan and Switzerland use a reporting period of four weeks; Canada uses a reporting period of one week.
1. The figure presents data between 2012 and 2016. The relevant year for each country is outlined in Table A B.1.
Source: EHIS-2, CCHS, SHS (2012), GEDA, NHIS (2013), CSLC. See detailed data source descriptions in Table A B.1.

241. When workers are absent from work, those with mental health conditions require more time off than those without (Figure A B.14). Given that a worker has been absent from work, those with mental health conditions take on average 33.6 days of leave per year, compared with 21.4 days for those with no mental health conditions. Longer absence durations for those with mental health conditions are observable within every country with the exception of Greece. While these differences are quite small for some countries such as Finland, Lithuania, and Poland, the difference is notable for other countries, including Switzerland, Ireland, and Belgium. Longer absence durations due to mental health conditions can be costly to workers, as they are associated with more severe depressive symptoms (Shin et al., 2018[86]), which in turn are associated with larger limitations in work functioning when returning to work (Lagerveld et al., 2010[87]).

242. Working time lost to mental disorder can be costly to employers as well. US research estimated that absenteeism due to major depressive disorders cost USD 23.3 billion in 2010 (Greenberg et al., 2015[88]). However, the same study estimates that this represented only 12% of the total incremental cost, echoing previous research that more than three quarters of the total workplace-related costs were due to presenteeism, or reduced productivity while at work (Stewart et al., 2003[89]; OECD, 2012[1]).

Figure A B.14. Persons with mental health conditions are also taking more days off when they are sick

Average annual number of sick days taken for those with at least one absence in the past year, by mental health status, mid-2010s[1]



Note: OECD average is the unweighted average of the depicted countries. Absence data is reported in aggregated bins. The figure presents the weighted average of the mid-point values of each bin. Data for Switzerland and Japan use reporting period of four weeks and are adjusted to a 12-month period.
1. The figure presents data between 2012 and 2016. The relevant year for each country is outlined in Table A B.1.
Source: EHIS-2, SHS (2012), GEDA, NHIS (2013), CSLC. See detailed data source descriptions in Table A B.1.

243. The prevalence of presenteeism highlights that many workers are capable of working with their mental health condition, but that they may require support to maintain their productivity. Research suggests that workers with depression had trouble with interpersonal, time management, and physical tasks, and that these issues can remain even after the symptoms of depression are treated (Adler et al., 2006[90]). This suggests that targeted interventions can help workers with mental health conditions to cope with the demands of work. Other research (Bubonya, Cobb-Clark and Wooden, 2017[91]; D'Souza et al., 2006[92]) has found that increased job security is associated with lower presenteeism, though it has an ambiguous effect on work absences. This research suggests that reducing and managing job stress can be an effective means of improving productivity. Mental health training for managers and developing effective back-to-work management processes can be key routes to achieving this goal (OECD, 2015[2]).

Definition and measurement

Figure A B.14 shows the resulting average number of sick days in the past year of all those with at least one day of absence, whereas Figure A B.13 shows the share of those with at least one absence in the past year. In many of the surveys used, absence data is reported in aggregated bins, which group together different ranges of sick leave durations. The analysis infers average values by computing the midpoint of each bin and using that midpoint value as the imputed sick leave duration for each worker. If there is an uneven distribution of actual leave days within a particular reported bin (for example, if every worker who took "1 to 9 days" of leave only took one day) then this imputed value approach will provide biased results. Consequentially, the analysis assumes an equal distribution of the number of days of sickness leave taken within aggregated bins.

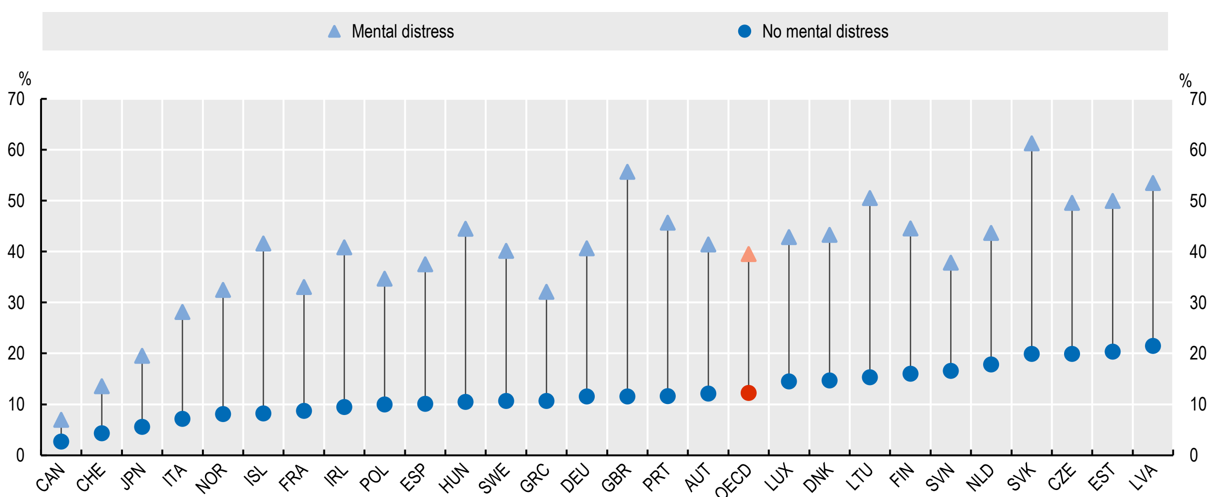
Mental health and comorbidity

244. Many people with mental health conditions also report a limiting physical disability. Figure A B.15 presents the co-morbidity of mental and limiting chronic general health problems. On average, 39.5% of individuals with mental health conditions face activity-limiting chronic health problems, compared with 12.2% for those without mental health conditions. While this gap is notable, still a majority of people with mental health conditions do not report such co-morbidity (approximately 60%), suggesting that mental health must be considered both individually and within the context of comorbid physical disabilities and not solely as a subset of a country's disability policy.

245. Further, interactions between physical health problems and mental health issues can be diverse and complex. For example, some physical and mental health problems are often found together, such as depression and chronic back pain (Patten, 2001[93]; Lépine and Briley, 2004[94]) or asthma and panic disorders (Carr, 1998[95]; Yellowlees et al., 1987[96]; Vermeulen et al., 2017[97]). In addition, treatment of patients with mental health problems can be complicated by poor adherence to medical treatment plans, possible cognitive impairment, and increased alcohol and substance abuse (Hirschfield, 2001[98]; Sato and Yeh, 2013[99]; Gallo et al., 2013[100]). Likewise, the existence of physical health problems can exacerbate or even generate mental health issues, such as anxiety and depression.

Figure A B.15. Mental health conditions are frequently comorbid with other limiting health conditions

Share of the working-age population that report a long-standing health problem that limits their general activity, by mental health status, mid-2010s[1]



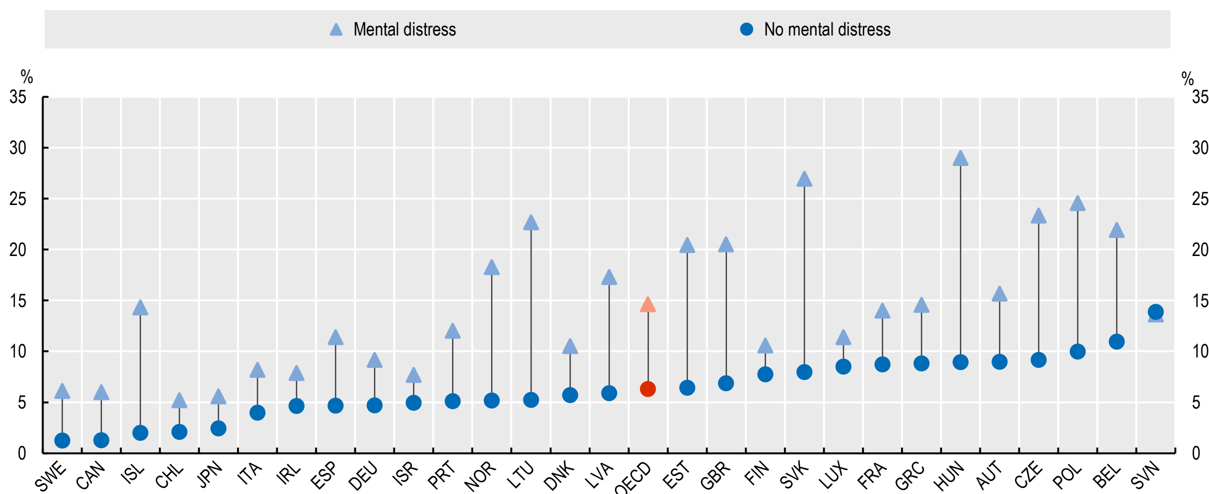
Note: OECD average is the unweighted average of the depicted countries. Individuals with mental distress have provided survey responses to a series of mental health questions that place them in the bottom quintile of respondents.
1. The figure presents data between 2012 and 2016. The relevant year for each country is outlined in Table A B.1
Source: EHIS-2, GEDA, CCHS, ENCAVI, CSLC. See detailed data source descriptions in Table A B.1

246. Oftentimes, comorbidity takes individuals out of the labour market. Figure A B.16 presents the share of individuals who report being unable to work due to either a permanent disability or early retirement, by mental health status. As noted in Figure A B.4, the policy environment in some countries encourages early retirement over disability benefits and so, to facilitate cross-country comparisons, Figure A B.16 presents a combined measure of the two reasons for not working. There are notable differences by mental health status. While, on average, 6.3% of people without mental health conditions report being unable to work due to either a permanent disability or taking early retirement, 14.6% of those with mental health

conditions report so. This represents a gap of 8.3 percentage points. This difference can be even greater in some countries, with there being a gap of almost 20 percentage points in Hungary (29% and 9% for those with and without mental health conditions, respectively), and gaps of at least 14 percentages points in Estonia, the Czech Republic, Poland, Lithuania, and Slovakia. However, some countries have smaller gaps, which is often the case when relatively few individuals leave work due to disability. Examples include Chile, Finland, Israel, Ireland, Japan, Luxembourg, and Slovenia, which all have gaps of less than 3.5 percentage points. The variety in these gaps suggests that the policy environment could play a role in encouraging workers with interacting health problems to either remain in work or search for employment.

Figure A B.16. Mental health and physical disability often combine to keep people out of work

Share of the working-age population that report being unable to work as a result of a permanent disability or early retirement, by mental health status, mid-2010s[1]



Note: OECD average is the unweighted average of the depicted countries. Individuals with mental distress have provided survey responses to a series of mental health questions that place them in the bottom quintile of respondents.
1. The figure presents data between 2012 and 2016. The relevant year for each country is outlined in Table A B.1.
Source: EHIS-2, GEDA, CCHS, ENCAVI, INHIS-2, CSLC. See detailed data source descriptions in Table A B.1.

Definition and measurement

Figure A B.15 presents an indicator commonly used to proxy the existence of a physical disability consisting of the combination of two separate questions. The first question asks about the existence of any chronic health problem. The second asks if this problem leads to a limitation of their general daily activity, either moderately or severely. Respondents who answer affirmative to both of those questions are assumed to have a long-term disability. Data for Japan indicates the existence of health problems currently affecting daily activities, and does not reference if the problem is chronic in nature. The indicator in Figure A B.16 presents the share of people who have instead decided not to work due to either disability or early retirement. Early retirement is included as, in some countries people who stop working due to a permanent disability tend to report that their main reason for choosing not to work is due to early retirement rather than due to the presence of a disability. In Japan, this indicator shows those who do not work, but want to, and cannot take up work due to health reasons.

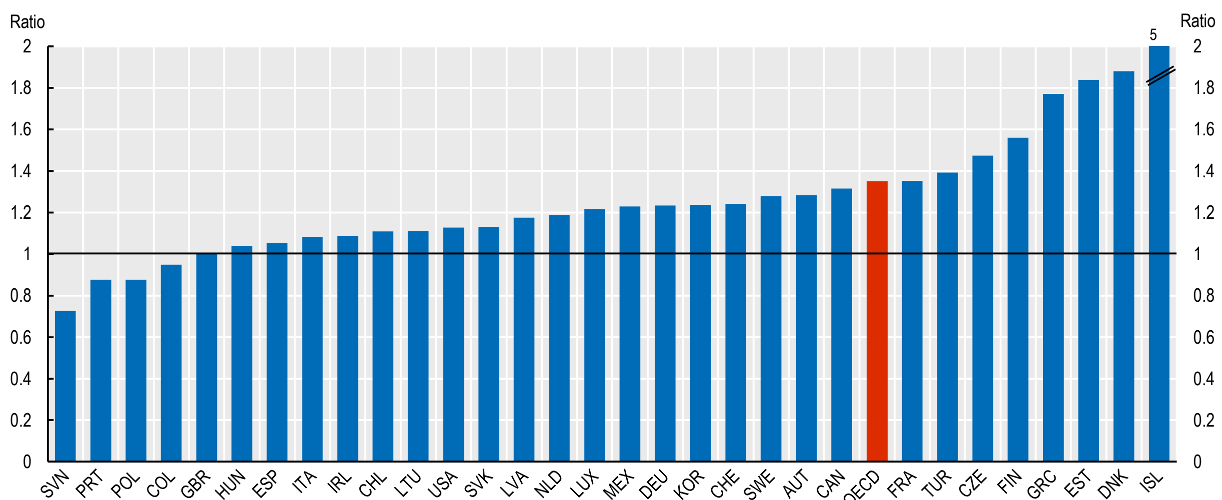
Youth

247. Mental health issues often manifest themselves at a young age, and can remain an ongoing issue throughout a person's life (Burke et al., 1990[101]; Patton et al., 2014[102]; Rohde et al., 2013[103]; Naicker et al., 2013[104]). The onset of mental health conditions such as depression and anxiety have been linked with decreased school performance (Owens et al., 2012[105]; Fröjd et al., 2008[106]). Childhood is also a critical time for the promotion of well-being and the formation of skills that prepare students for their work life. Thus, it is important to quickly identify and address mental health issues in youth.

248. Figure A B.17 presents a ratio of the share of students that repeated a grade during their schooling, comparing those indicating mental distress to those not. It shows that, on average across the OECD, students indicating mental distress are 35% more likely to have repeated a grade. This is not the case for all countries. In Slovenia, Portugal, Poland, and Colombia, this group of students is slightly less likely to have repeated a grade, while in the United Kingdom there is no difference between the two groups. On the other side of the spectrum, students indicating mental distress in Greece, Estonia, Denmark and Iceland are all at least 75% more likely to have repeated a grade.

Figure A B.17. Students indicating mental distress are more likely to have repeated a grade

Students who have repeated a grade during their schooling, ratio with over without mental distress, 2018



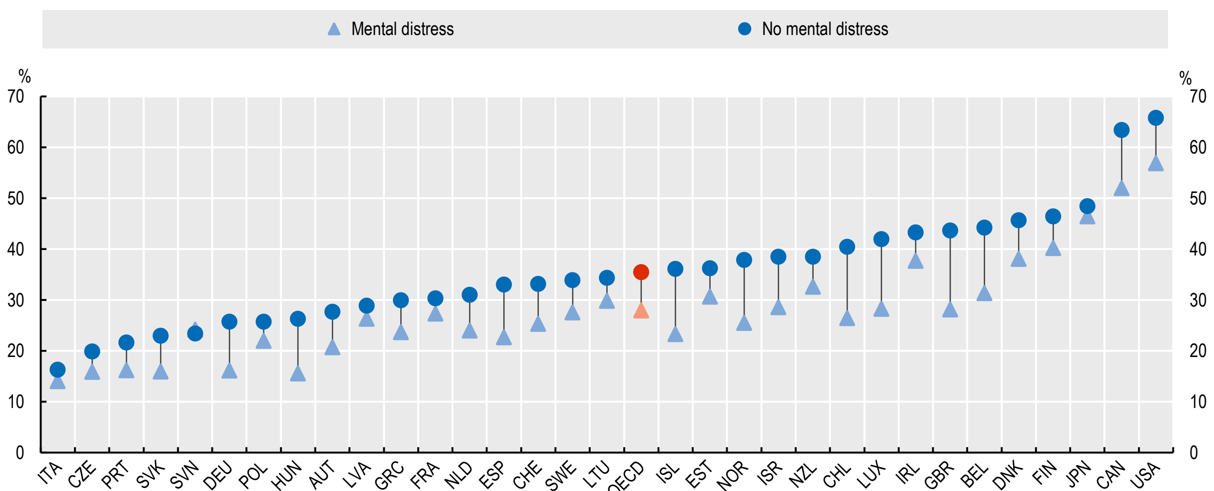
Note: OECD average is the unweighted average of the depicted countries. A value above one indicates that those students indicating mental distress were more likely to have repeated a grade. Students classed as having mental distress scored in the bottom 20% of respondents to the following battery of questions: Thinking about yourself and how you normally feel: how often do you feel as described below? Happy, Scared, Lively, Miserable, Proud, Afraid, Joyful Sad, Cheerful. Components were recoded for comparability. The ratio for Iceland is 4.99.
Source: PISA (2018). See detailed data source descriptions in Table A B.1.

249. Grade repetition risks disrupting social connections with a student's peer group, removing a potential source of protection against mental health problems (La Greca and Harrison, 2005[107]). Further, grade repetition can reduce the chance of graduating high school, especially if the retention occurs later in their school career (Roderick, 1994[108]; Jacob and Lefgren, 2009[109]). If retained students do manage to graduate high school, they still face a risk of lower overall educational attainment (Manacorda, 2012[110]). Similar outcomes are evident for people with mental health conditions more generally in Figure A B.18, which shows that those with mental health conditions are less likely to reach a high level of education: Only 28% of those with mental health conditions had achieved a tertiary education, compared with 35% for those not experiencing mental health conditions.

250. The negative outcomes for students with mental health conditions or experiencing mental distress highlight the need for quickly identifying struggling students and for providing both targeted support and universal prevention measures (OECD, 2015[2]). These can include school-based measures to improve resilience, life skills, and emotional intelligence that can be both effective and cost effective (Weare and Nind, 2011[111]). More targeted interventions, such as cognitive behavioural therapy and interpersonal therapy have a strong evidence base and can reduce the risk of students with depressive symptoms from relapse (Merry et al., 2012[112]). Evidence suggests that the most effective measures to reduce drop-out rates target students on three levels: within school, outside of school, and at a systematic level (Lyche, 2010[113]). Examples include targeted mentoring for at-risk students, and encouraging the involvement of parents in their children's education, and supporting strong positive relationships between students and teachers.

Figure A B.18. Persons with mental health conditions are less likely to complete a high-level education

Share of working age individuals with an education at ISCED 5 or higher, by mental health status, mid-2010s[1]



Note: OECD average is the unweighted average of the depicted countries. Individuals with mental distress have provided survey responses to a series of mental health questions that place them in the bottom quintile of respondents.
1. The figure presents data between 2012 and 2016. The relevant year for each country is outlined in Table A B.1.
Source: EHIS-2, CCHS, SHS (2012), GEDA, ENCAVI, INHIS-3, GSS, NHIS (2013), CSLC. See detailed data source descriptions in Table A B.1.

Definition and measurement

Figure A B.17 indicates the ratio of students who have ever repeated a grade, and compares those indicating mental distress to those not indicating mental distress. This measure of mental health status is taken at the time of the survey, generally when a student is 15 years old. However, students may have repeated a grade at any point over their schooling career. This ambiguity makes it difficult to determine a causality in the relationship between grade repetition and the existence of a mental health condition. The International Standard Classification of Education (ISCED) used in Figure A B.18 categorises educational achievement into nine broad groups. Groups above ISCED-5 indicate various levels of tertiary education, including bachelor, master's, and doctoral degrees or equivalent.

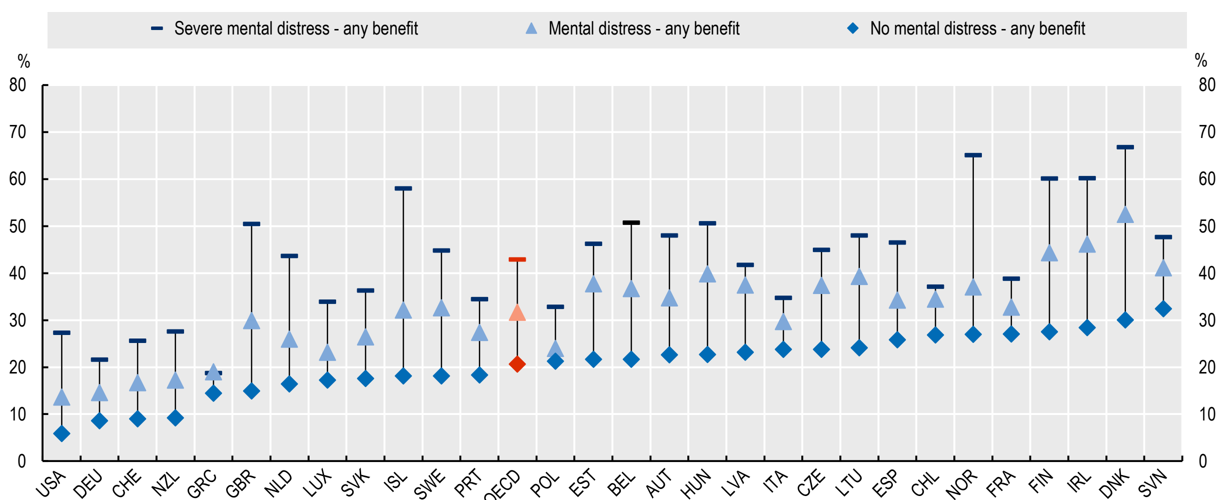
Social protection

251. Beyond health services, social benefits are key mechanisms with which governments provide support to people in need. Figure A B.19 presents the share of workers who receive any type of income support by their mental health status. On average within the countries examined, 20.6% of those without mental health conditions received some form of income support compared with 31.7% of those with mild-to-moderate mental health conditions and 42.8% for people with more severe mental health conditions. While many people with mental health conditions receive social protection benefits, it is notable that many do not. For instance, about three in four individuals with mental health conditions in Switzerland, Greece, Germany and New Zealand do not receive any income support.

252. Those people who are receiving social protection benefits may likely be long-term benefit recipients. Oftentimes, mental health issues are not identified or addressed early within a spell of unemployment or inactivity (OECD, 2012[1]). This represents a missed opportunity as ignoring (mental) health concerns often leads to poor labour market reintegration (OECD, 2015[2]). Early action, when a person is newly out of work, can help to retain their connection to the labour market. Once that connection is lost, either through the passage of time, inadequate work incentives, or excessive barriers to work, it is difficult to re-establish.

Figure A B.19. Persons with mental health conditions are more likely to be in need of social benefits

Share of the working-age population receiving main social protection benefits, by mental health status, mid-2010s[1]



Note: OECD average is the unweighted average of depicted countries. Individuals are considered as benefits recipients if the income that they receive from benefits comprises more than 5% of their total gross income (with the exception of Chile, Germany, New Zealand and the United States, where all benefit recipients are included). Data for the United States does not indicate the receipt of unemployment benefits, and so estimates represent a lower-bound estimate of benefit receipts.
1. The figure presents data between 2012 and 2016. The relevant year for each country is outlined in Table A B.1.
Source: EU-SILC, GSOEP, ENCAVI, GSS, NHIS (2013). See detailed data source descriptions in Table A B.1.

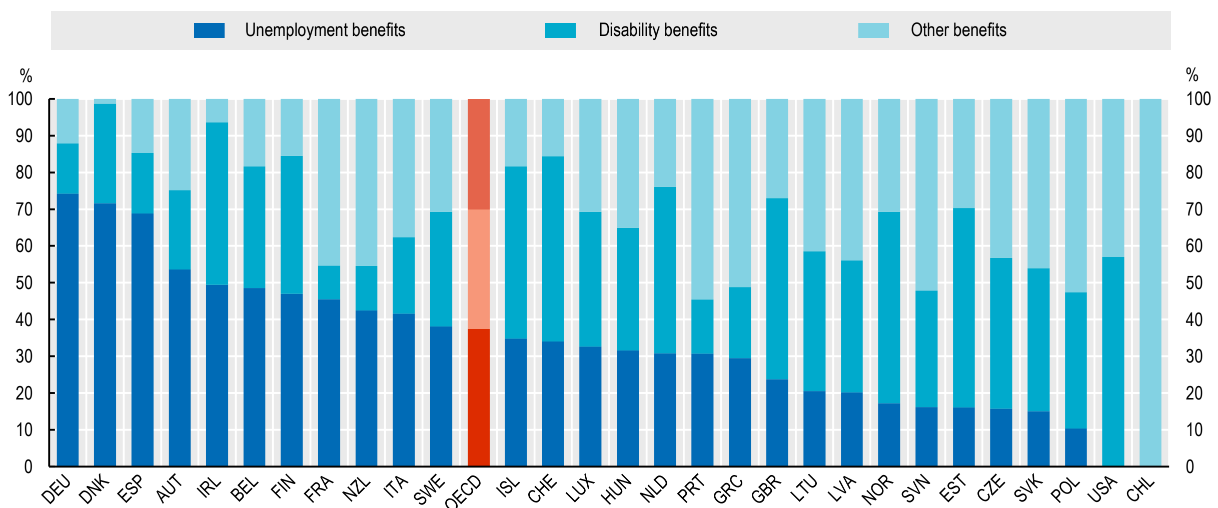
253. Figure A B.20 presents the distribution of the type of main benefits received by individuals with mental health conditions. The distribution of benefit types varies, both within and between countries. On average, unemployment benefits (37%), disability benefits (33%), and other types of income support (30%) are equally important for the population with mental health conditions. This distribution, however, varies across countries. Persons with mental health conditions in Denmark, Germany, Spain, and Austria are more likely to receive unemployment benefits than any other type of benefit, provided they receive a benefit

at all. In Estonia, Switzerland, and Norway, on the other hand, they are most likely to receive disability benefits as their primary benefit. In yet other countries such as Slovenia, Portugal, Poland and Greece, persons with mental health conditions are more likely to receive benefits other than unemployment or disability.

254. People with severe mental health conditions are on average slightly more likely to be receiving disability benefits (39.3% of those receiving benefits) than are those with mild-to-moderate conditions (30%). Previous evidence suggests that people with mental health issues make the bulk of new disability claims, and is more often cited as the reason for work problems when people have multiple health issues (OECD, 2015[2]; OECD, 2012[1]). This highlights the need for an awareness of mental health issues and the work capacity of those with poor mental health within the disability insurance system, and that policy attempts facilitate, where possible, a return to work. Early interventions to curb disability claims, financial incentives for workers and employers to hire and retain workers with mental health issues, and restricting full disability benefits to those who truly cannot work, can all help towards this goal (OECD, 2015[2]).

Figure A B.20. Persons with mental health conditions receive a range of income-support payments

Distribution by type of benefits paid for persons with mental health conditions who receive benefits, mid-2010s[1]



Note: OECD average is the unweighted average of depicted countries, excluding Chile and the United States. In cases where individuals receive multiple benefits, they are assigned to the benefit that provides the most income. Data for the United States does not indicate the receipt of unemployment benefits. Data for Chile does not distinguish by benefit type.

1. The figure presents data between 2012 and 2016. The relevant year for each country is outlined in Table A B.1.

Source: EU-SILC, GSOEP, ENCAVI, GSS, NHIS (2013). See detailed data source descriptions in Table A B.1.

Definition and measurement

Income support benefits considered in Figure A B.19 include unemployment benefits, social assistance, disability benefits, old age benefits (for working-age workers), sickness benefits, lone-parent benefits, survivor benefits, and other income-replacement benefits. Recipients for whom social protection benefits provide less than 5% of their total income are assumed to receive no benefit. In Figure A B.20, those individuals who receive multiple benefits are attributed to the benefit providing the most income.

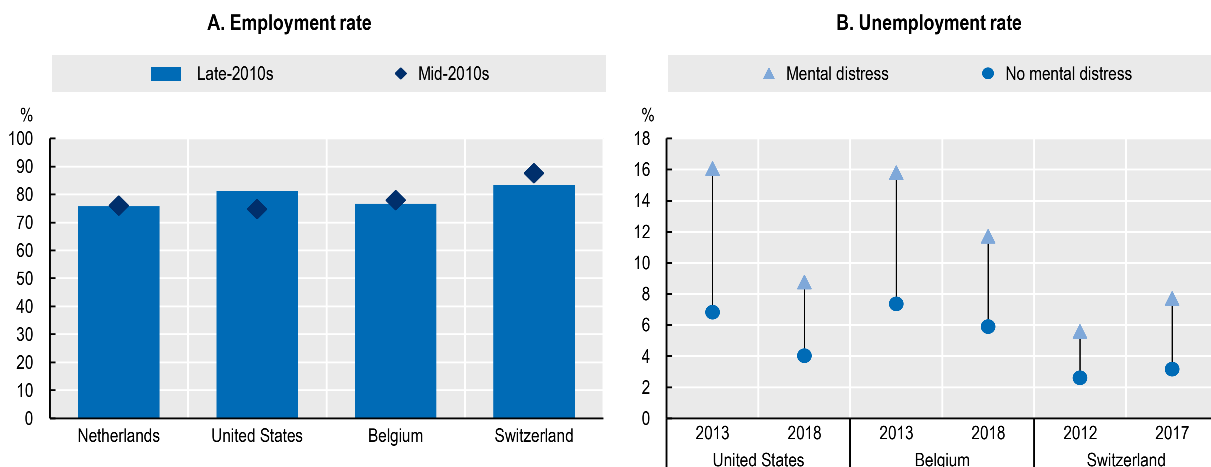
Trends

255. Most of the indicators throughout this report rely on data collected between 2012 and 2015, as data that is more recent was not yet available for the majority of OECD countries. Within Europe, the third wave of the European Health Interview Survey is expected to be released and data to publicly available in early 2021. This data will provide updated insights for many European countries. In anticipation of these new data, this section presents some first trends for those countries for which data is available for two points in time (namely, Belgium, the Netherlands, Switzerland and the United States). The following figures review indicators from previous sections in order to provide insight into possible trends.

256. Figure A B.21 presents the employment ratio and unemployment rate indicators previously presented in Figure A B.1 and Figure A B.3. Of the four countries examined, the employment ratio improved only for one country, the United States, while it declined for Belgium and Switzerland (and held steady in the Netherlands). The employment rate for both those with and without mental health conditions improved in Belgium, the Netherlands and the United States. However, it is only in the United States that the employment rate for those with mental health conditions improved more than for those without, which is reflected in an improved employment ratio (Panel A). Employment rates slightly declined over the period in Switzerland for those with mental health conditions, while they held constant for those without such conditions.

Figure A B.21. Improved labour market conditions can shrink the employment and unemployment gap for persons with mental health conditions

Employment rate (Panel A) and unemployment rate (Panel B), by mental health status, mid-2010s and late-2010s

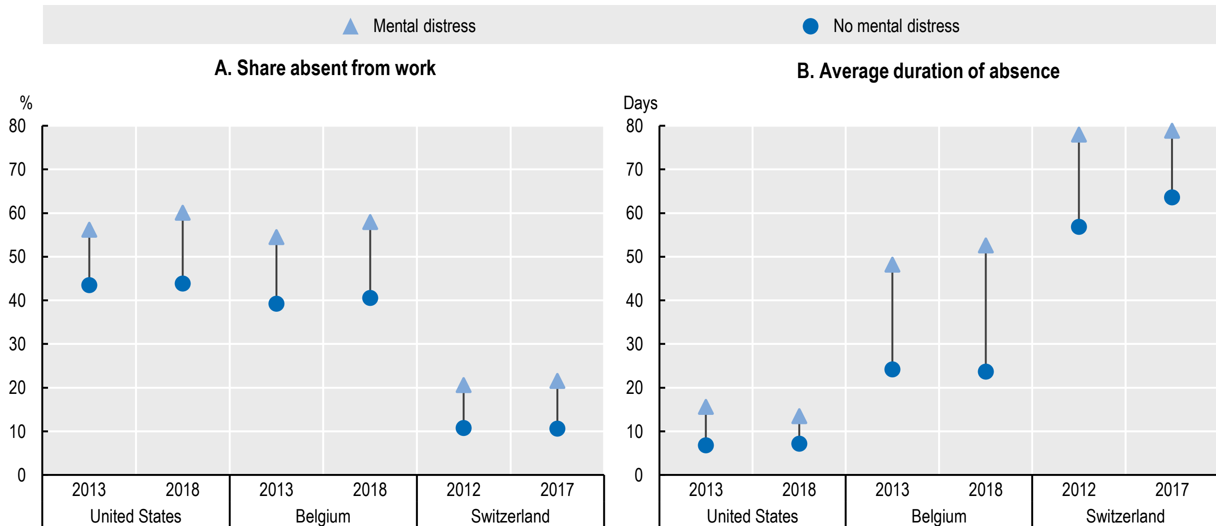


Note: Refer to notes for Figure A B.1 for Panel A, and Figure A B.3 for Panel B.
Source: EHIS-2, EHIS-3, SHS (2012, 2017), NHIS (2013, 2018). See detailed data source descriptions in Table A B.1.

257. Figure A B.22 and Figure A B.23 present updated indicators for those previously presented in Figure A B.7, Figure A B.13, Figure A B.14, and Figure A B.18. They provide information on the prevalence and duration of sickness-related work absences, and on the educational attainment and the prevalence of part-time work. In general, these indicators have changed little in the intervening period of data collection. When compared to the country rankings presented in earlier sections, these updated data generally do not change a country's ranking. This lack of variation implies two conclusions. First, the indicators presented in previous sections remain valid and relevant, despite the age of the data. Second, the lack of variation suggests that countries still have opportunities to enact policies to address the gap in outcomes between those who report mental health conditions distress and those who do not report such conditions.

Figure A B.22. The prevalence and duration of sick leave has changed little in the past five years

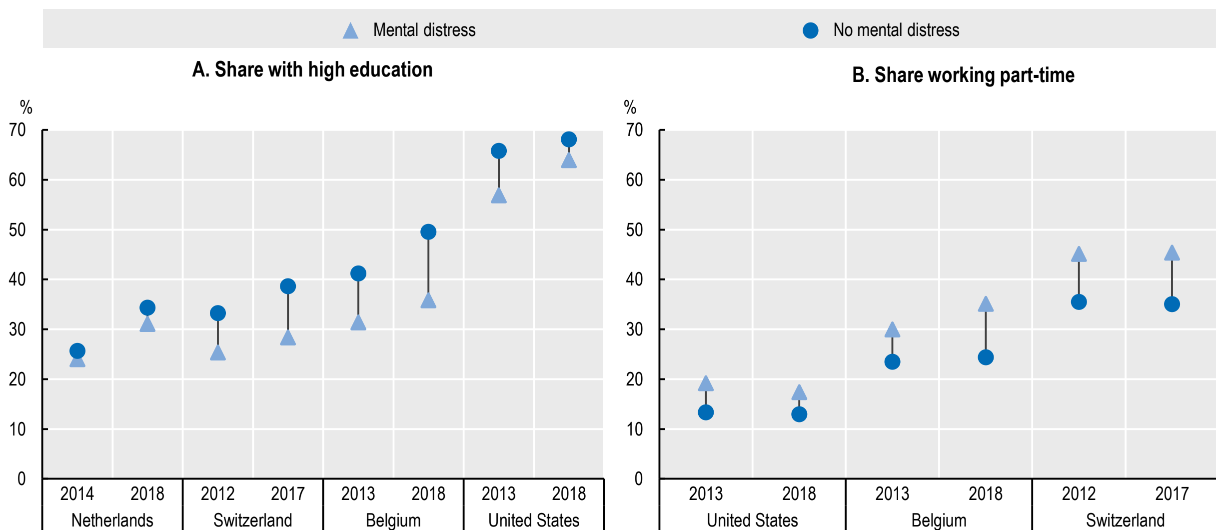
Share of workers absent from work (Panel A) and average duration of absence in days per year (Panel B), by mental health status, mid-2010s and late-2010s



Note: Refer to notes for Figure A B.13 for Panel A and Figure A B.14 for Panel B.
Source: EHIS-2, EHIS-3, SHS (2012, 2017), NHIS (2013, 2018). See detailed data source descriptions in Table A B.1.

Figure A B.23. Workers are better educated than five years ago, while the proportions working part-time have changed only little

Share of workers with a high level of educational attainment (ISCED 5-8 or equivalent) (Panel A) and share working part-time hours (Panel B), by mental health status, mid-2010s and late-2010s



Note: Refer to notes for Figure A B.18 for Panel A and Figure A B.7 for Panel B.
Source: EHIS-2, EHIS-3, SHS (2012, 2017), NHIS (2013, 2018). See detailed data source descriptions in Table A B.1.

Data sources

Table A B.1. Data sources and country coverage

Abbreviation	Data Source	Year(s)	Country Coverage
EHIS-2	European Health Interview Survey wave 2	2013	Belgium and the United Kingdom
		2014	Czech Republic, Estonia, Greece, Spain, France, Latvia, Lithuania, Luxembourg, Hungary, Netherlands, Austria, Poland, Portugal, Slovenia, Slovakia, Finland and Sweden
		2015	Denmark, Ireland, Italy, Iceland and Norway
GEDA	Gesundheit in Deutschland aktuell (Current Health in Germany)	2014-15	Germany
EHIS-3	European Health Interview Survey wave 3	2018	Belgium, Netherlands
CCHS	Canadian Community Health Survey – Mental Health Questionnaire	2012	Canada
ENCAVI	Encuesta de Calidad de Vida y Salud	2015-2016	Chile
INHIS-2	Israeli National Health Interview Survey wave 2	2007-2010	Israel
INHIS-3	Israeli National Health Interview Survey wave 3	2013-2015	Israel
SHS	Swiss Health Survey	2012	Switzerland
		2017	
GSS	General Social Survey	2014	New Zealand
CSLC	Comprehensive Survey of Living Conditions	2013	Japan
NHIS	National Health Interview Survey	2013	United States
		2018	
EU-SILC	European Union Statistics on Income and Living Conditions – Module on Well-Being	2013	Austria, Belgium, Czech Republic, Denmark, Estonia, Finland, France, Greece, Hungary, Iceland, Ireland, Italy, Latvia, Lithuania, Luxembourg, Netherlands, Norway, Poland, Portugal, Slovakia, Slovenia, Spain, Sweden, Switzerland, United Kingdom
GSOEP	German Socio-Economic Panel	2014	Germany
PISA	Programme for International Student Assessment	2018	Austria, Canada, Chile, Colombia, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Korea, Latvia, Lithuania, Luxembourg, Mexico, Netherlands, Poland, Portugal, Slovakia, Slovenia, Spain, Sweden, Switzerland, Turkey, United Kingdom, United States

References

Adler, D. et al. (2006), "Job performance deficits due to depression", *American Journal of Psychiatry*, Vol. 163/9, pp. 1569-1576, http://dx.doi.org/10.1176/ajp.2006.163.9.1569. [90]

Alonso, J. et al. (2004), "Prevalence of mental disorders in Europe: results from the European Study of the Epidemiology of Mental Disorders (ESEMeD) project", *Acta Psychiatrica Scandinavica*, Vol. 109/s420, pp. 21-27, http://dx.doi.org/10.1111/j.1600-0047.2004.00327.x. [56]

Andrade, L. et al. (2014), "Barriers to mental health treatment: Results from the WHO World Mental Health surveys", *Psychological Medicine*, Vol. 44/6, pp. 1303-1317, http://dx.doi.org/10.1017/S0033291713001943. [83]

Andrén, D. (2011), ""Half empty or half full": The importance of the definition of part-time sick leave when estimating its effects", *Working Paper*, No. 4/2011, Örebro University, Örebro, http://www.oru.se/Akademier/Handelshogskolan/Forskning/Working-papers/ (accessed on 2 June 2020). [67]

Anthes, E. (2016), "Pocket psychiatry: mobile mental-health apps have exploded onto the market, but few have been thoroughly tested", *Nature*, Vol. 532/7597, pp. 20-24. [23]

Artazcoz, L. et al. (2004), "Unemployment and Mental Health: Understanding the Interactions Among Gender, Family Roles, and Social Class", *American Journal of Public Health*, Vol. 94/1, pp. 82-88, http://dx.doi.org/10.2105/AJPH.94.1.82. [77]

Australian Government Department of Health (2019), *Prioritising Mental Health – national headspace network*, https://www.health.gov.au/sites/default/files/prioritising-mental-health-national-headspace-network_0.pdf (accessed on 25 February 2021). [33]

Barnay, T. (2016), "Health, work and working conditions: a review of the European economic literature", *European Journal of Health Economics*, Vol. 17/6, pp. 693-709, http://dx.doi.org/10.1007/s10198-015-0715-8. [79]

Biffl, G. and T. Leoni (2009), *Arbeitsplatzbelastungen, arbeitsbedingte Krankheiten und Invalidität*, Institut für Wirtschaftsforschung (WIFO), Wein, http://www.donau-uni.ac.at/mis (accessed on 26 May 2020). [64]

Brand, J. (2015), "The Far-Reaching Impact of Job Loss and Unemployment", *Annual Review of Sociology*, Vol. 41/1, pp. 359-375, http://dx.doi.org/10.1146/annurev-soc-071913-043237. [62]

Browne, J. et al. (2018), "Faces of Joblessness in Estonia: A People-centred perspective on employment barriers and policies", *OECD Social, Employment and Migration Working Papers*, No. 206, OECD Publishing, Paris, https://dx.doi.org/10.1787/6d9cd656-en. [38]

Bubonya, M., D. Cobb-Clark and M. Wooden (2017), “Mental health and productivity at work: Does what you do matter?”, *Labour Economics*, Vol. 46, pp. 150-165, http://dx.doi.org/10.1016/j.labeco.2017.05.001. [91]

Burke, K. et al. (1990), “Age at Onset of Selected Mental Disorders in Five Community Populations”, *Archives of General Psychiatry*, Vol. 47/6, pp. 511-518, http://dx.doi.org/10.1001/archpsyc.1990.01810180011002. [101]

Carr, R. (1998), “Panic disorder and asthma: Causes, effects and research implications”, *Journal of Psychosomatic Research*, Vol. 44/1, pp. 43-52, http://dx.doi.org/10.1016/S0022-3999(97)00137-2. [95]

Clark, A. (2003), “Unemployment as a Social Norm: Psychological Evidence from Panel Data”, *Journal of Labor Economics*, Vol. 21/2, pp. 323-351, http://dx.doi.org/10.1086/345560. [60]

Clement, S. et al. (2015), “What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies”, *Psychological Medicine*, Vol. 45/1, pp. 11-27, http://dx.doi.org/10.1017/S0033291714000129. [52]

Codony, M. et al. (2009), “Perceived need for mental health care and service use among adults in Western Europe: Results of the ESEMeD Project”, *Psychiatric Services*, Vol. 60/8, pp. 1051-1058, http://dx.doi.org/10.1176/ps.2009.60.8.1051. [80]

Corrigan, P. (2004), *How stigma interferes with mental health care*, http://dx.doi.org/10.1037/0003-066X.59.7.614. [75]

Corrigan, P., B. Druss and D. Perlick (2014), “The impact of mental illness stigma on seeking and participating in mental health care”, *Psychological Science in the Public Interest, Supplement*, Vol. 15/2, pp. 37-70, http://dx.doi.org/10.1177/1529100614531398. [53]

Danish government (2018), *Vi løfer i fællesskab: En samlet handlingsplan for psykiatrien frem mod 2025 (We run together: A comprehensive action plan for psychiatry to 2025)*, https://www.sum.dk/~/media/Filer%20-%20Publikationer_i_pdf/2018/Psykiatriplan-Vi-loefter-i-faellesskab-sept-2018/Vi-loefter-i-faellesskab-tilgaengelig-pdf.pdf. [116]

Department for Work and Pensions and Department for Health and Social Care (2017), *Improving Lives The Future of Work, Health and Disability*, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/663399/improving-lives-the-future-of-work-health-and-disability.PDF (accessed on 16 September 2020). [26]

Department of Veterans’ Affairs (2019), *Environmental Scan of Mental Health Reform in Australia Final Report*, https://www.dva.gov.au/sites/default/files/files/health%20and%20wellbeing/mental/environmental-scan-of-mental-health-reform-in-australia.pdf (accessed on 2 September 2020). [9]

D’Souza, R. et al. (2006), “Work demands, job insecurity and sickness absence from work. How productive is the new, flexible labour force?”, *Australian and New Zealand Journal of Public Health*, Vol. 30/3, pp. 205-212, http://dx.doi.org/10.1111/j.1467-842X.2006.tb00859.x. [92]

Eplov, L. and T. Christensen (2018), *Inklusion - Resultater fra IPS projektet: Individuelt Planlagt Job med Støtte (IPS) og træning i sociale og kognitive færdigheder til personer med en alvorlig sindslidelse [Inclusion - Results form the IPS Project and training in social and cognitive skills for people experiencing a severe mental health condition]*, https://star.dk/media/9153/ips-rapport.pdf (accessed on 23 February 2021). [120]

Eurostat (2021), *Early leavers from education and training*, https://ec.europa.eu/eurostat/databrowser/view/t2020_40/default/table?lang=en (accessed on 24 February 2021). [32]

Forbes, M. and R. Krueger (2019), "The Great Recession and Mental Health in the United States", *Clinical Psychological Science*, Vol. 7/5, pp. 900-913, http://dx.doi.org/10.1177/2167702619859337. [122]

Fröjd, S. et al. (2008), "Depression and school performance in middle adolescent boys and girls", *Journal of Adolescence*, Vol. 31/4, pp. 485-498, http://dx.doi.org/10.1016/j.adolescence.2007.08.006. [106]

Gajendran, R. and D. Harrison (2007), "The Good, the Bad, and the Unknown About Telecommuting: Meta-Analysis of Psychological Mediators and Individual Consequences", *Journal of Applied Psychology*, Vol. 92/6, pp. 1524-1541, http://dx.doi.org/10.1037/0021-9010.92.6.1524. [118]

Gallo, J. et al. (2013), "Long term effect of depression care management on mortality in older adults: Follow-up of cluster randomized clinical trial in primary care", *BMJ (Online)*, Vol. 346/7911, http://dx.doi.org/10.1136/bmj.f2570. [100]

Government of Ireland (2019), *Part II-Expenditure Allocations 2019-21*, http://www.budget.gov.ie/Budgets/2020/Documents/Budget/Estimates%20of%20Receipts%20and%20Expen (accessed on 24 February 2021). [30]

Greenberg, P. et al. (2015), "The Economic Burden of Adults With Major Depressive Disorder in the United States (2005 and 2010)", *Journal of Clinical Psychiatry*, Vol. 76/2, pp. 155-162, http://dx.doi.org/10.4088/JCP.14m09298. [88]

Herbig, B., N. Dragano and P. Angerer (2013), "Health in the Long-term Unemployed", *Deutsches Arzteblatt International*, Vol. 110/23-24, pp. 413-419, http://dx.doi.org/10.3238/arztebl.2013.0413. [46]

Hirschfield, R. (2001), "The Comorbidity of Major Depression and Anxiety Disorders", *The Primary Care Companion to The Journal of Clinical Psychiatry*, Vol. 03/06, pp. 244-254, http://dx.doi.org/10.4088/pcc.v03n0609. [98]

HM Government (2019), *Health is everyone's business: Proposals to reduce ill health-related job loss*. [18]

Høgelund, J. and A. Holm (2011), "The effects of part-time sick leave for employees with mental disorders", *Working Paper*, No. 01:2011, Danish National Centre for Social Research. [69]

Independent Mental Health Taskforce to the NHS in England (2016), *The Five Year Forward View for Mental Health*, https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf (accessed on 28 June 2020). [16]

Initiative Neue Qualität der Arbeit (2020), *Offensive Psychische Gesundheit*, https://inqa.de/DE/vernetzen/offensive-psychische-gesundheit/uebersicht.html (accessed on 24 February 2021). [21]

Jacob, B. and L. Lefgren (2009), "The Effect of Grade Retention on High School Completion", *American Economic Journal: Applied Economics*, Vol. 1/3, pp. 33-58, http://dx.doi.org/10.1257/app.1.3.33. [109]

Kessler, R. et al. (2005), *Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the national comorbidity survey replication*, http://dx.doi.org/10.1001/archpsyc.62.6.593. [28]

Kessler, R. et al. (2005), *Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication*, American Medical Association, http://dx.doi.org/10.1001/archpsyc.62.6.617. [55]

Knabe, A. and S. Ratzel (2011), "Scarring or Scaring? The Psychological Impact of Past Unemployment and Future Unemployment Risk", *Economica*, Vol. 78/310, pp. 283-293, http://dx.doi.org/10.1111/j.1468-0335.2009.00816.x. [63]

KPMG (2020), *Report on the value for money of the IPS Trial - for the Department of Social Services*, https://www.pc.gov.au/inquiries/completed/mental-health/draft. [40]

KPMG (2019), *Final Report for the Evaluation of the Individual Placement and Support Trial - Department for Social Services*, https://www.dss.gov.au/sites/default/files/documents/08_2019/individual-placement-and-support-trial-evaluation-report-june-2019.pdf (accessed on 9 September 2020). [39]

KPMG and DSS (2019), *Final Report for the Evaluation of the Individual Placement and Support Trial - Department for Social Services*, https://www.dss.gov.au/sites/default/files/documents/08_2019/individual-placement-and-support-trial-evaluation-report-june-2019.pdf (accessed on 9 September 2020). [115]

Kuehner, C. (2017), "Why is depression more common among women than among men?", *The Lancet Psychiatry*, Vol. 4/2, pp. 146-158, http://dx.doi.org/10.1016/S2215-0366(16)30263-2. [72]

La Greca, A. and H. Harrison (2005), "Adolescent peer relations, friendships, and romantic relationships: Do they predict social anxiety and depression?", *Journal of Clinical Child and Adolescent Psychology*, Vol. 34/1, pp. 49-61, http://dx.doi.org/10.1207/s15374424jccp3401_5. [107]

Lagerveld, S. et al. (2010), "Factors Associated with Work Participation and Work Functioning in Depressed Workers: A Systematic Review", *Journal of Occupational Rehabilitation*, Vol. 20, pp. 275-292, http://dx.doi.org/10.1007/s10926-009-9224-x. [87]

Lépine, J. and M. Briley (2004), "The epidemiology of pain in depression", *Human Psychopharmacology*, Vol. 19/SUPPL. 1, pp. S3-S7, http://dx.doi.org/10.1002/hup.618. [94]

Loveless, L. (2019), *Employment Advisers in Improving Access to Psychological Therapies: Process Evaluation Report*, ICF International, https://www.gov.uk/government/collections/research-reports (accessed on 16 September 2020). [27]

Lyche, C. (2010), "Taking on the Completion Challenge: A Literature Review on Policies to Prevent Dropout and Early School Leaving", *OECD Education Working Paper*, No. 53, OECD Publishing, Paris, http://dx.doi.org/10.1787/5km4m2t59cmr-en. [113]

Manacorda, M. (2012), "The cost of grade retention", *Review of Economics and Statistics*, Vol. 94/2, pp. 596-606, http://dx.doi.org/10.1162/REST_a_00165. [110]

Markussen, S., A. Mykletun and K. Roed (2010), "The Case for Presenteeism", *IZA Discussion Paper*, No. 5243, IZA, Bonn, https://papers.ssrn.com/sol3/papers.cfm?abstract_id=1720325 (accessed on 2 June 2020). [68]

Melzer, D., J. Buxton and E. Villamil (2004), "Decline in common mental disorder prevalence in men during the sixth decade of life", *Social Psychiatry and Psychiatric Epidemiology*, Vol. 39/1, pp. 33-38, http://dx.doi.org/10.1007/s00127-004-0704-1. [66]

Mental Health Services in the Capital Region of Denmark (2020), *IBBIS*, https://www.psykiatri-regionh.dk/Kvalitet-og-udvikling/udvikling/ibbis/Sider/default.aspx (accessed on 3 September 2020). [37]

Merry, S. et al. (2012), *Cochrane Review: Psychological and educational interventions for preventing depression in children and adolescents*, John Wiley & Sons, Ltd, http://dx.doi.org/10.1002/ebch.1867. [112]

MHLW (2019), *2018 Stress check seido no jisshi joukyou (Implementation of stress check system)*, https://www.mhlw.go.jp/content/11303000/000582829.pdf (accessed on 25 August 2020). [34]

MHLW (2018), *2017 Stress check seido no jisshi joukyou (Implementation of stress check system)*, https://www.mhlw.go.jp/content/11303000/000582827.pdf (accessed on 25 August 2020). [114]

Ministry of Health (2019), *Response to the Inquiry into Mental Health and Addiction*, https://www.health.govt.nz/system/files/documents/information-release/response_to_the_inq.pdf. [12]

Mojtabai, R. et al. (2011), "Barriers to mental health treatment: Results from the National Comorbidity Survey Replication", *Psychological Medicine*, Vol. 41/8, pp. 1751-1761, http://dx.doi.org/10.1017/S0033291710002291. [54]

Murphy, G. and J. Athanasou (1999), "The effect of unemployment on mental health", *Journal of Occupational and Organizational Psychology*, Vol. 72/1, pp. 83-99, http://dx.doi.org/10.1348/096317999166518. [59]

Naicker, K. et al. (2013), "Social, demographic, and health outcomes in the 10 years following adolescent Depression", *Journal of Adolescent Health*, Vol. 52/5, pp. 533-538, http://dx.doi.org/10.1016/j.jadohealth.2012.12.016. [104]

NDIS (2020), *Mental health and the NDIS*, https://www.ndis.gov.au/understanding/how-ndis-works/mental-health-and-ndis (accessed on 3 September 2020). [41]

New Zealand Treasury (2019), *The Wellbeing Budget*, https://treasury.govt.nz/sites/default/files/2019-05/b19-wellbeing-budget.pdf (accessed on 2 September 2020). [13]

NHS (2020), *Apps Library: National Health Service*, https://www.nhs.uk/apps-library/ (accessed on 2 June 2020). [24]

Nieuwenhuijsen, K. et al. (2020), "Interventions to improve return to work in depressed people", *Cochrane Database of Systematic Reviews*, http://dx.doi.org/10.1002/14651858.cd006237.pub4. [36]

Octopus Group (2020), *Global investment in mental health technology surges above half a billion pounds*, https://octopusgroup.com/newsroom/latest-news/global-investment-in-mental-health-technology-surges-above-half-a-billion-pounds/ (accessed on 18 September 2020). [22]

OECD (2021), *Short-Term Labour Market Statistics : Monthly Unemployment Rates*, https://stats.oecd.org/index.aspx?queryid=36324# (accessed on 26 February 2021). [45]

OECD (2021), *Supporting jobs and companies: a bridge to the recovery phase*, OECD Publishing. [123]

OECD (2021), *Tackling the mental health impact of the COVID-19 crisis through an integrated government response, OECD Policy Responses to Coronavirus (COVID-19)*, OECD Publishing. [42]

OECD (2020), *Education responses to COVID-19: Embracing digital learning and online collaboration, OECD Policy Responses to Coronavirus (COVID-19)*, OECD Publishing, https://www.oecd.org/coronavirus/policy-responses/education-responses-to-covid-19-embracing-digital-learning-and-online-collaboration-d75eb0e8/ (accessed on 1 October 2020). [48]

OECD (2020), *Lessons for Education from COVID-19: A Policy Maker's Handbook for More Resilient Systems*, OECD Publishing, Paris, https://dx.doi.org/10.1787/0a530888-en. [47]

OECD (2020), *OECD Digital Economy Outlook 2020*, OECD Publishing, Paris, https://dx.doi.org/10.1787/bb167041-en. [49]

OECD (2020), *OECD Employment Outlook 2020: Worker Security and the COVID-19 Crisis*, OECD Publishing, Paris, https://dx.doi.org/10.1787/1686c758-en. [51]

OECD (2020), *OECD follow-up questionnaire on the Recommendation of the Council on Integrated Mental Health, Skills and Work Policy*. [8]

OECD (2020), *OECD Mental Health Performance Benchmarking Data and Policy Questionnaires*, OECD Publishing, Paris. [14]

OECD (2020), *OECD Mental Health Performance Benchmarking Data and Policy Questionnaires*, OECD Publishing, Paris. [19]

OECD (2020), *Productivity gains from teleworking in the post COVID-19 era: How can public policies make it happen?, OECD Policy Responses to Coronavirus (COVID-19)*, https://www.oecd.org/coronavirus/policy-responses/productivity-gains-from-teleworking-in-the-post-covid-19-era-a5d52e99/ (accessed on 1 October 2020). [117]

OECD (2020), "Recent trends in employment protection legislation", in *OECD Employment Outlook 2020: Worker Security and the COVID-19 Crisis*, OECD Publishing, Paris, http://dx.doi.org/10.1787/af9c7d85-en. [70]

OECD (2020), *Waiting Times for Health Services: Next in Line*, OECD Health Policy Studies, OECD Publishing, Paris, https://dx.doi.org/10.1787/242e3c8c-en. [25]

OECD (2019), *Health in the 21st Century: Putting Data to Work for Stronger Health Systems*, OECD Health Policy Studies, OECD Publishing, Paris, https://dx.doi.org/10.1787/e3b23f8e-en. [43]

OECD (2018), *Children & Young People's Mental Health in the Digital Age: Shaping the Future*. [119]

OECD (2018), *Good Jobs for All in a Changing World of Work: The OECD Jobs Strategy*, OECD Publishing, Paris, https://dx.doi.org/10.1787/9789264308817-en. [7]

OECD (2016), *Ministerial Statement: Building More Resilient and Inclusive Labour Markets, OECD Labour and Employment Ministerial Meeting*, https://www.oecd.org/employment/ministerial/labour-ministerial-statement-2016.pdf. [5]

OECD (2015), *Adults, Computers and Problem Solving: What's the Problem?*, OECD Skills Studies, OECD Publishing, Paris, https://dx.doi.org/10.1787/9789264236844-en. [50]

OECD (2015), *Fit Mind, Fit Job: From Evidence to Practice in Mental Health and Work*, Mental Health and Work, OECD Publishing, Paris, https://dx.doi.org/10.1787/9789264228283-en. [2]

OECD (2012), *Sick on the Job?: Myths and Realities about Mental Health and Work*, Mental Health and Work, OECD Publishing, Paris, https://dx.doi.org/10.1787/9789264124523-en. [1]

OECD (2011), *OECD Employment Outlook 2011*, OECD Publishing, Paris, https://dx.doi.org/10.1787/empl_outlook-2011-en. [124]

OECD (2008), *OECD Employment Outlook 2008*, OECD Publishing, Paris, https://dx.doi.org/10.1787/empl_outlook-2008-en. [121]

OECD/European Union (2018), *Health at a Glance: Europe 2018: State of Health in the EU Cycle*, OECD Publishing, Paris/European Union, Brussels, https://dx.doi.org/10.1787/health_glance_eur-2018-en. [6]

Ojeda, V. and S. Bergstresser (2008), "Gender, Race-Ethnicity, and Psychosocial Barriers to Mental Health Care: An Examination of Perceptions and Attitudes among Adults Reporting Unmet Need", *Journal of Health and Social Behavior*, Vol. 49/3, pp. 317-334, http://dx.doi.org/10.1177/002214650804900306. [73]

Olesen, S., P. Butterworth and B. Rodgers (2012), "Is poor mental health a risk factor for retirement? Findings from a longitudinal population survey", *Social Psychiatry and Psychiatric Epidemiology*, Vol. 47/5, pp. 735-744, http://dx.doi.org/10.1007/s00127-011-0375-7. [65]

Owens, M. et al. (2012), "Anxiety and depression in academic performance: An exploration of the mediating factors of worry and working memory", *School Psychology International*, Vol. 33/4, pp. 433-449, http://dx.doi.org/10.1177/0143034311427433. [105]

Patel, V. et al. (2018), "The Lancet Commission on global mental health and sustainable development", *The Lancet*, Vol. 392/10157, pp. 1553-1598, http://dx.doi.org/10.1016/s0140-6736(18)31612-x. [4]

Patten, S. (2001), “Long-term medical conditions and major depression in a Canadian population study at waves 1 and 2”, *Journal of Affective Disorders*, Vol. 63/1-3, pp. 35-41, http://dx.doi.org/10.1016/S0165-0327(00)00186-5. [93]

Patton, G. et al. (2014), “The prognosis of common mental disorders in adolescents: A 14-year prospective cohort study”, *The Lancet*, Vol. 383/9926, pp. 1404-1411, http://dx.doi.org/10.1016/S0140-6736(13)62116-9. [102]

Paul, K. and K. Moser (2009), “Unemployment impairs mental health: Meta-analyses”, *Journal of Vocational Behavior*, Vol. 74/3, pp. 264-282, http://dx.doi.org/10.1016/j.jvb.2009.01.001. [58]

Plaisier, I. et al. (2008), “Work and family roles and the association with depressive and anxiety disorders: Differences between men and women”, *Journal of Affective Disorders*, Vol. 105/1-3, pp. 63-72, http://dx.doi.org/10.1016/j.jad.2007.04.010. [78]

Psycom (2020), *Map of actors producing online content on mental health issues*, https://www.psycom.org/wp-content/uploads/2020/10/Cartographie-PSYCOM-2020_small.pdf (accessed on 24 February 2021). [20]

Reiter, J., A. Dobmeyer and C. Hunter (2018), “The Primary Care Behavioral Health (PCBH) Model: An Overview and Operational Definition”, *Journal of Clinical Psychology in Medical Settings*, Vol. 25/2, pp. 109-126, http://dx.doi.org/10.1007/s10880-017-9531-x. [84]

Riecher-Rössler, A. (2017), *Sex and gender differences in mental disorders*, Elsevier Ltd, http://dx.doi.org/10.1016/S2215-0366(16)30348-0. [71]

Roderick, M. (1994), “Grade Retention and School Dropout: Investigating the Association”, *American Educational Research Journal*, Vol. 31/4, pp. 729-759, http://dx.doi.org/10.3102/00028312031004729. [108]

Rohde, P. et al. (2013), “Key Characteristics of Major Depressive Disorder Occurring in Childhood, Adolescence, Emerging Adulthood, and Adulthood”, *Clinical Psychological Science*, Vol. 1/1, pp. 41-53, http://dx.doi.org/10.1177/2167702612457599. [103]

SAMHSA (2020), *Project AWARE (Advancing Wellness and Resiliency in Education) State Education Agency Grants | SAMHSA*, https://www.samhsa.gov/grants/grant-announcements/sm-20-016 (accessed on 3 September 2020). [31]

Sato, S. and T. Yeh (2013), *Challenges in treating patients with Major depressive disorder: The impact of biological and social factors*, Springer, http://dx.doi.org/10.1007/s40263-012-0028-8. [99]

Schnyder, N. et al. (2017), *Association between mental health-related stigma and active help-seeking: Systematic review and meta-analysis*, Royal College of Psychiatrists, http://dx.doi.org/10.1192/bjp.bp.116.189464. [74]

Seland, I. et al. (2020), *Evaluering av ordning med fylkesvise mobbeombud for barnehage og grunnskole [Evaluation of a national anti-bullying ombudsmen scheme for kindergarten and primary school]*, Oslo Metropolitan University, http://www.oslomet.no/om/nova (accessed on 25 February 2021). [29]

Shatkin, J. and M. Belfer (2004), “The Global Absence of Child and Adolescent Mental Health Policy”, *Child and Adolescent Mental Health*, Vol. 9/3, pp. 104-108, http://dx.doi.org/10.1111/j.1475-3588.2004.00090.x. [15]

Shin, C. et al. (2018), "Sickness absence indicating depressive symptoms of working population in South Korea", *Journal of Affective Disorders*, Vol. 227, pp. 443-449, http://dx.doi.org/10.1016/j.jad.2017.11.030. [86]

Steel, Z. et al. (2014), "The global prevalence of common mental disorders: a systematic review and meta-analysis 1980–2013", *International Journal of Epidemiology*, Vol. 43/2, pp. 476-493, http://dx.doi.org/10.1093/ije/dyu038. [57]

Stevenson, D. and P. Farmer (2017), *Thriving at work: The Stevenson/Farmer review of mental health and employers*. [35]

Stewart, W. et al. (2003), "Cost of Lost Productive Work Time among US Workers with Depression", *Journal of the American Medical Association*, Vol. 289/23, pp. 3135-3144, http://dx.doi.org/10.1001/jama.289.23.3135. [89]

Strandh, M. et al. (2014), "Unemployment and mental health scarring during the life course", *European Journal of Public Health*, Vol. 24/3, pp. 440-445, http://dx.doi.org/10.1093/eurpub/cku005. [61]

Swedish Ministry of Health and Social Affairs (2019), *För att börja med något nytt måste man sluta med något gammalt: Förslag för en långsiktigt hållbar styrning inom området psykisk hälsa [Proposals for long-term sustainable governance in the field of mental health]*. [17]

Taskforce on Children and Young People's Mental Health (2018), *Children & Young People's Mental Health Task Force Delivery Plan*, https://www.gov.scot/publications/children-young-peoples-mental-health-taskforce-delivery-plan/ (accessed on 2 September 2020). [10]

Thornicroft, G. et al. (2017), *Undertreatment of people with major depressive disorder in 21 countries*, Royal College of Psychiatrists, http://dx.doi.org/10.1192/bjp.bp.116.188078. [81]

Van Beljouw, I. et al. (2010), "Reasons and determinants for not receiving treatment for common mental disorders", *Psychiatric Services*, Vol. 61/3, pp. 250-257, http://dx.doi.org/10.1176/ps.2010.61.3.250. [82]

Vermeulen, F. et al. (2017), "Relationship between the sensation of activity limitation and the results of functional assessment in asthma patients", *Journal of Asthma*, Vol. 54/6, pp. 570-577, http://dx.doi.org/10.1080/02770903.2016.1242138. [97]

Villatoro, A. et al. (2018), "Perceived Need for Mental Health Care: The Intersection of Race, Ethnicity, Gender, and Socioeconomic Status", *Society and Mental Health*, Vol. 8/1, pp. 1-24, http://dx.doi.org/10.1177/2156869317718889. [76]

Weare, K. and M. Nind (2011), "Mental health promotion and problem prevention in schools: what does the evidence say? | Health Promotion International | Oxford Academic", *Health Promotion International*, Vol. 26/1, pp. 29-69, https://academic.oup.com/heapro/article/26/suppl_1/i29/687644 (accessed on 29 July 2020). [111]

WHO (2020), *The impact of COVID-19 on mental, neurological and substance use services*, https://www.who.int/publications/i/item/978924012455 (accessed on 26 February 2021). [44]

WHO and Calouste Gulbenkian Foundation (2014), *Social determinants of mental health*, http://www.who.int/mental_health/publications/gulbenkian_paper_social_determinants_of_mental_health/en/ (accessed on 30 September 2020). [3]

Williams, A. (2020), “The Next Step in Integrated Care: Universal Primary Mental Health Providers”, *Journal of Clinical Psychology in Medical Settings*, Vol. 27/1, pp. 115-126, http://dx.doi.org/10.1007/s10880-019-09626-2. [85]

World Bank Group and World Health Organisation (2016), *Out of the Shadows: Making Mental Health a Global Priority*. [11]

Yellowlees, P. et al. (1987), “Psychiatric morbidity in patients with chronic airflow obstruction”, *Medical Journal of Australia*, Vol. 146/6, pp. 305-307, http://dx.doi.org/10.5694/j.1326-5377.1987.tb120267.x. [96]