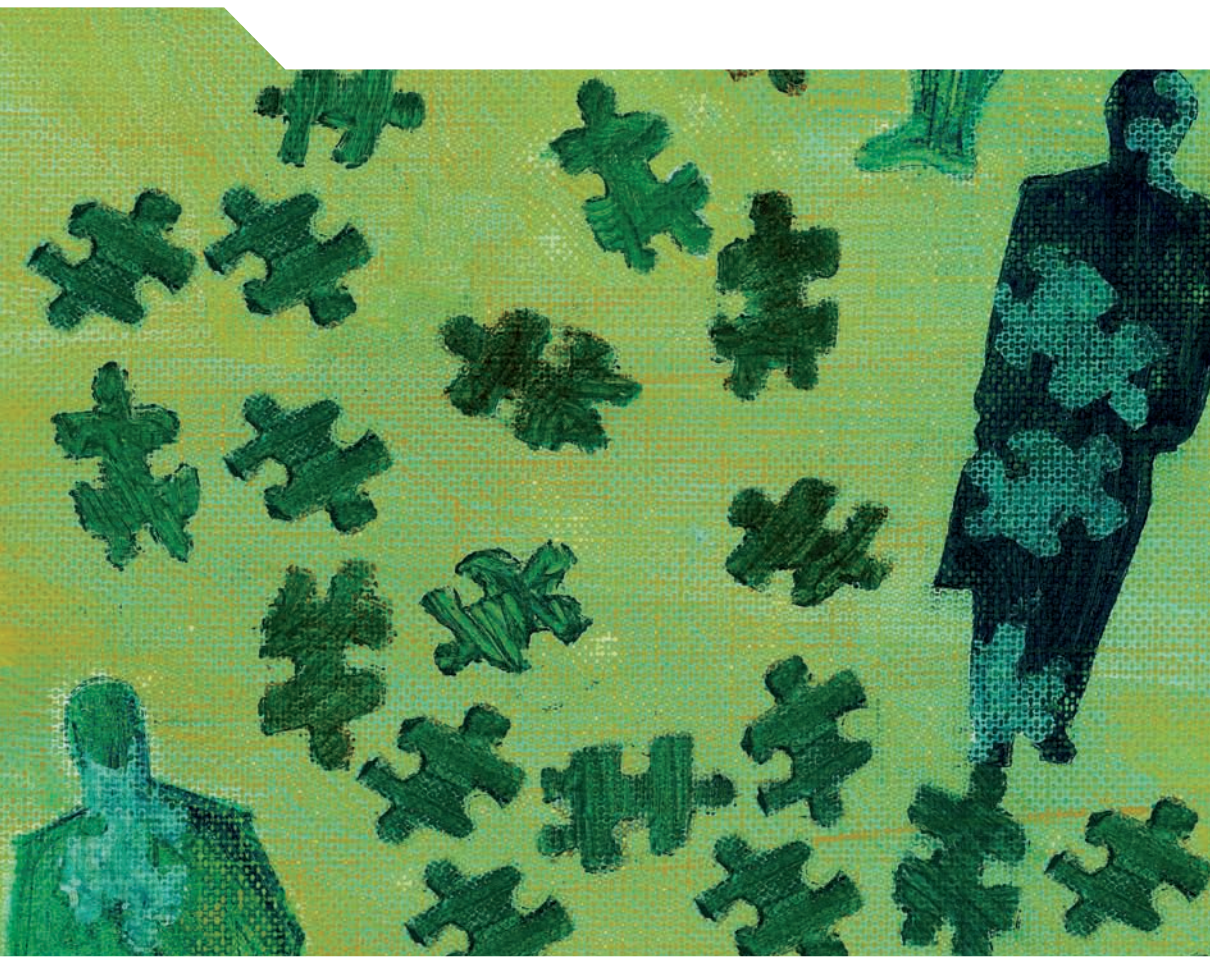
Mental Health and Work

BELGIUM



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Mental Health and Work: Belgium

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Foreword

Tackling mental ill-health of the working-age population is becoming a key issue for labour market and social policies in many OECD countries. It is an issue that has been neglected for too long despite creating very high and increasing costs to people and society at large. OECD governments increasingly recognise that policy has a major role to play in improving the employment opportunities for people with mental ill-health, including very young people; helping those employed but struggling in their jobs; and avoiding long-term sickness and disability caused by a mental disorder.

A first OECD report on this subject, *Sick on the Job? Myths and Realities about Mental Health and Work*, published in January 2012, identified the main underlying policy challenges facing OECD countries by broadening the evidence base and questioning some myths around the links between mental ill-health and work. This report on Belgium is the first in a series of reports looking at how these policy challenges are being tackled in selected OECD countries, covering issues such as the transition from education to employment, the workplace, the institutions providing employment services for job seekers, the transition into permanent disability and the capacity of the health system. The other reports look at the situation in Australia, Austria, Denmark, the Netherlands, Norway, Sweden, Switzerland, and the United Kingdom. Together, these nine reports aim to deepen the evidence on good mental-health-and-work policy. Each report also contains a series of detailed country-specific policy recommendations. As there has not been a previous report on sickness, disability and work in Belgium (in contrast to most other countries participating in the project), some of the discussion in this report will address the sickness and disability system in general rather than focussing solely on mental-health issues.

Work on this review was a collaborative effort carried out jointly by the Employment Analysis and Policy Division and the Social Policy Division of the OECD Directorate for Employment, Labour and Social Affairs. The report was prepared by Veerle Miranda under the supervision of Christopher Prinz. Statistical work was provided by Dana Blumin and Maxime Ladaique. Valuable comments were provided by John Martin, Stefano Scarpetta, Mark Keese and Monika Queisser. The report also includes

comments received from experts and various Belgian ministries and authorities, including Freddy Falez of Université Libre de Bruxelles, the National Institute for Sickness and Invalidity Insurance, the Independent Mutualities MLOZ, the Federal Public Service for Health, Food Chain Safety and Environment, the Federal Public Service for Employment, Labour and Social Dialogue, Forem and the Flemish Ministry of Education and Training.

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Acronyms and abbreviations

AWIPH	Agence Wallonne pour l'Intégration des Personnes Handicapées
BTOM	*Bijzondere Tewerkstellingsondersteunende Maatregel* (Special Employment Support Measure)
CEFA	Centres d'Education et de formation en Alternance
CLB	*Centrum voor Leerlingenbegeleiding* (Centre for Student Guidance)
DSM-IV-TR	Diagnostic and Statistical Manual of Mental Disorders (fourth edition, text revision)
EWCS	European Working Conditions Survey
GA	*Gespecialiseerde Arbeidsonderzoeksdienst* (External employment research centre specialised in in-depth multidisciplinary)
GHQ	General Health Questionnaire
GOB	*Gespecialiseerde Opleidings- en Begeleidingsdienst* (Specialised centre for the training, guidance and intermediation of job seekers with a work disability)
GP	General Practitioner
GTB	*Gespecialiseerde Traject Bepalings- en Begeleidingsdienst* (Centre specialised in the activation of MMPP job seekers)
IBO	*Individuele Beroepsopleiding in de Onderneming* (Individual Vocational Training in the Enterprise)
ICD	International Classification of Diseases
IDI	Identification, Diagnosis and Intervention
MMPP	Medical, Mental, Psychological or Psychiatric problems
MST	*Medisch Schooltoezicht* (Centre for Medical Surveillance at Schools)
OCMW	Public Social Welfare Centre
PES	Public Employment Service
PHARE	Personne Handicapée Autonomie Recherchée

PMS	Psycho-Medical-Social Centre
PSE	Service de Promotion de la Santé à l'École
RATOG	*Risico-Analyse Tool voor Ongewenst Gedrag* (Risk-Analysis Tool for Undesirable Behaviour)
RATOG-KMO	*Risico-Analyse Tool voor Ongewenst Gedrag in Kleine en Middelgrote Organisaties* (Risk Analysis Tool for Undesirable Behaviour for Small and Medium-Sized Enterprises)
RIZIV/INAMI	National Institute for Sickness and Invalidity Insurance
RVA/ONEM	National Employment Office
SOBANE	Screening, Observation, Analysis, and Expertise
SME	Small and Medium-Sized Enterprise
VAPH	*Vlaams Agentschap voor Personen met een Handicap* (Flemish Agency for People with a Disability)
VDAB	*Vlaamse Dienst voor Arbeidsbemiddeling en Beroepsopleiding* (Flemish Public Employment Service)
WAIS	Wechsler Adult Intelligence Scale

Executive summary

Throughout the OECD, mental ill-health is increasingly recognised as a problem for social and labour market policy; a problem that is creating significant costs for people, employers and the economy at large by lowering employment, raising unemployment and generating productivity losses. The institutional set-up in Belgium has great potential in addressing the challenges of mental ill-health and work, mainly for three reasons. First, the advanced labour legislation has a strong focus on the prevention of mental ill-health at work; second, people with a mental disorder typically receive unemployment benefits rather than disability benefits upon job loss, hence remaining closely attached to the labour market which facilitates their reintegration; and third, the integrated sickness and disability benefit system provides ideal conditions for sickness monitoring, early intervention and effective return-to-work mechanisms. However, the current system is poorly implemented, passive and reactive and is not used to prevent labour market withdrawal of people with mental illness. The recent rapprochement by the public employment services (especially in Flanders) towards the mental health sector and other benefit systems to (re-)integrate people with mental disorders is a promising evolution to improve the labour outcomes and social well-being of people with mental ill-health. A more active mindset of employers, occupational health services, and sickness insurance companies (called mutualities) will be required, as well as systematic co-financing mechanisms between the different sectors to develop models of service co-operation and integration. The ongoing mental health reform provides the ideal opportunity for integrating health and employment services.

The OECD recommends to Belgium to:

- Further integrate children and students with special needs in mainstream education and improve the transition to employment.
- Rigorously implement and monitor employers' obligations with respect to psychosocial problems and increase sanctions for non-compliance.

- Systematically involve occupational health specialists in the retention and reintegration of sick employees.
- Systematise the co-operation between mutualities and public employment services.
- Develop employment-oriented mental health care and experiment with ways to integrate health and employment services.

Assessment and recommendations

People with mental disorders underperform in the labour market. In Belgium, their employment rates are 15 percentage points lower and their unemployment rates 10 percentage points higher than those of people without mental disorders. Many of those who are employed struggle in their jobs (four in five workers with a mental disorder report reduced performance at work) and disability claims based on mental ill-health are frequent and rising. About one third of the 260 000 disability insurance beneficiaries and a significant proportion of the 160 000 disability allowance beneficiaries have a mental disorder as primary cause for their benefit claim. In sum, the total costs for the society, employers, individuals and their families are large, amounting to an estimated 3.4% of GDP in Belgium.

The Belgian system has much potential to address the challenges of mental ill-health and work

Belgium can build upon an institutional set-up system with a number of structural strengths that are not yet exploited to the best possible extent. In particular, the obligation for employers to have an occupational health service and the integrated sickness and disability benefit system with unified funding schemes and assessment procedures provide ideal conditions for close sickness monitoring, early intervention and effective return-to-work mechanisms. In addition, Belgium is one of the few countries with explicit instructions in the labour legislation concerning the need to prevent mental ill-health at work and all key players, including employers, occupational doctors, and sickness insurance companies (called mutualities), are required to be actively engaged in reintegrating sick employees. However, the practical implementation of the legislation is far from optimal and the system is currently not used to prevent labour market withdrawal of people with mental illness. A more pro-active approach of all key stakeholders would greatly improve the labour market inclusion of people with mental disorders.

Activating employers, occupational doctors and mutualities

First, financial incentives for employers to prevent mental illness and retain employees with a mental disorder are weak due to a relatively short period of continued wage payment in case of sickness absence. As a result, employers generally do not play an active role in sickness and disability management and rarely engage their occupational health services for job retention or reintegration of sick employees. Few companies see the benefit of undertaking the legally required psychosocial risk assessment and sanctions for non-compliance with the law are too low to motivate employers.

Second, occupational health services in Belgium employ both occupational doctors specialised in medical surveillance and prevention advisors specialised in risk management (including for mental health issues). They are thus in an ideal position to support employers in sickness and disability management of their workforces. Yet, conflicting responsibilities for occupational doctors generate mistrust among both employers and employees, thwarting their co-operation. For instance, while occupational doctors are supposed to help sick employees returning to their job, they can also declare an employee disabled and give the employer the right to dismiss the worker in question without entitlement to a notice period or severance payment. Employers from their side seldom know the prevention advisor responsible for psychosocial issues until they are contacted with respect to a complaint made by one of their employees and regard this as an intrusion of their domain.

Third, mutualities remain quite passive and strongly focussed on controlling their clients' sickness status, despite their legal obligation to assist sick workers in their return to work. The few integration measures at their disposal are not always suitable for people with mental health problems and there is no systematic communication between the mutualities and occupational doctors. Recent initiatives of the public employment services (PES) to provide activation services to sickness and disability beneficiaries are a promising trend, but so far there is very little take-up as the lack of a legal framework creates too much uncertainty for beneficiaries about their benefit entitlement. For the co-operation between the PES and mutualities to become successful, a clear change in the mindset among both the mutuality doctors and their clients is necessary which could be achieved through the provision of better training and information for mutuality doctors and the development of a legal framework in which inconsistent rules are removed.

Addressing mental ill-health among unemployment beneficiaries

Belgium faces a unique situation in the activation of people with a mental disorder relying on working-age benefits. Contrary to many other OECD countries where jobless people with a mental disorder are predominantly found in the disability benefit system, in Belgium, a large proportion of them remain in the unemployment benefit system. Spending on sickness and disability is also lower than spending on unemployment while the opposite is true in nearly all OECD countries.

The prominent role of the unemployment benefit system for people with a mental disorder is related to a number of factors. First, the time-unlimited unemployment benefit renders the more stringent disability benefit less attractive for people with mental ill-health. While there are strict job-search and availability requirements for job seekers, mental ill-health is a valid reason for refusing job offers and long-term unemployment beneficiaries with multiple problems (including mental ill-health) are seldom suspended from the system. In addition, the unemployment benefit system could be perceived as more permanent and secure than the sickness and disability system as disability beneficiaries are regularly controlled for health improvements while this is not necessarily the case for unemployment beneficiaries. Finally, until very recently the financial incentives to apply for disability benefits were limited as benefit levels of both systems were comparable. Yet, since November 2012, unemployment benefits have become more degressive and less generous, which could potentially generate a higher demand for disability benefits, as has been the case in many other OECD countries where unemployment benefits have become more tightly managed, including, for instance, stricter job-search monitoring and requirements.

The advantage of the current situation in Belgium is that people with mental health problems losing their job remain closely attached to the labour market, hence promoting their re-activation. Harvesting the potential of this setup requires more attention to the needs of this group. The recent awareness in the PES of mental health problems among unemployment beneficiaries is a promising start to improve the labour market outcomes and social well-being of people with mental ill-health. Pilot projects for people with severe mental disorders have been developed in co-operation with the mental health and welfare sector, and programmes are gradually being opened to beneficiaries of the disability and social welfare systems. However, to further develop the co-operation a more active stance is required of employers, occupational health services, and mutualities. Also systematic co-financing mechanisms between the different sectors are needed to share the activation costs according to the accrued benefits.

Finally, more attention to mild and moderate mental disorders among job seekers is necessary to fully address the problem.

Developing employment-oriented mental health care

Better labour market inclusion of people with mental disorders will hinge to a certain extent on the implementation of the ongoing mental health reform and the attention the mental health sector will devote to employment. In particular, this sector in Belgium is still predominantly focussed on hospital care for people with a severe mental disorder and the referral to specialist services is problematic due to a complex system with long waiting lists for treatment and a lack of reimbursement of psychotherapy sessions. The introduction of continuous care networks, in which the different care levels (*i.e.* general practitioners and other primary care providers, the centres for mental health and the psychiatric hospitals or facilities) closely co-operate, will be vital for effective service provision.

So far, the Belgian health care system devotes little to no attention to employment. The recent invitation to the labour ministries to participate in the mental health care reform, therefore, is an ideal opportunity to start developing ways to integrate health and employment services.

Addressing the early onset of mental disorders

Mental illness often commences at an early age and requires adequate support to prevent negative repercussions during working life. The Belgian school system has comprehensive services for mental health promotion and school drop-out prevention. Yet, more efforts need to be made to keep children with behavioural and emotional problems in mainstream schools in order to promote their social integration and future chances in the labour market. The development of internal care structures in Flemish schools in recent years (in particular in primary education) with a key role for the teacher as primary actor supported by care teachers within the school and external centres for student guidance are a promising evolution to better address the needs of children within mainstream education and should be further developed at the secondary-education level. It could also serve as an example for the education policy in the French Community. Finally, the centres for student guidance, which are ideally placed to co-ordinate all external support and services, do not always have the authority and financial resources to do so.

An abrupt ending of the services provided by the school system at the moment of finishing education can be particularly harmful for youth with mental health problems who regularly accumulate several social disadvantages. The transition from school to work is often difficult in

Belgium in any case, with high unemployment rates among youth as a consequence. The regional PES have devoted a lot of attention to youth unemployment in recent years, but a more pro-active approach and close co-operation with schools and the centres for student guidance, as well as with the welfare and health services, are necessary to provide integrated support for youth with mental health problems.

Summary of the main OECD recommendations for Belgium

Key policy challenges	Policy recommendations
1. There is limited attention to mental health issues in mainstream education	• Provide specialised support in the mainstream school system; • Further develop internal care structures in schools and give centres for student guidance the authority and resources to co-ordinate all external support.
2. The transition from school to work is often difficult	• Ensure relevant work experience for all students before they leave education; • Develop a career guidance system with co-operation from the centres for student guidance and the PES; • Oblige the PES to assist school-leavers in their job search.
3. Incentives for employers to prevent mental illness and retain sick employees are weak	• The risk-assessment obligations should be rigorously implemented and monitored, and non-compliance sanctions should be raised significantly; • Make longer-term sick leave more costly for the employer.
4. Occupational health specialists are not involved in the retention and reintegration of sick employees	• Limit regular medical check-ups to free up resources for sickness matters; • Abolish the possibility of dismissal of a sick employee without a notice period; • Occupational health specialists should play a role in on-the-job coaching and continuous support.
5. Mutualities are too passive in managing sickness absences	• Make mutualities financially responsible for activating sickness and disability beneficiaries; • Strengthen their sickness monitoring obligations; • Systematise the co-operation between the mutuality doctor and the occupational doctor or, if reintegration is not possible, with the PES.

Summary of the main OECD recommendations for Belgium *(cont'd)*

Key policy challenges	Policy recommendations
6. There is no activation of disability allowance beneficiaries, many of who have a mental disorder	• Broaden benefit eligibility assessments to take into account the claimants' work capacity; • Strengthen reintegration measures for this group in co-operation with the PES; • Eliminate the strong disincentives to start working for child disability allowance beneficiaries.
7. PES awareness of mental disorders among job seekers is rising, but PES programmes to assist such job seekers have had limited success so far	• Develop a legal framework for better co-operation between the PES and the health and welfare sectors; • Provide funding to expand PES programmes to: *i)* employees; *ii)* people with moderate mental health problems; and *iii)* recipients of social assistance and disability benefits.
8. The mental health sector is predominantly focussed on hospital care for people with a severe mental disorder	• Make co-operation with the PES a part of the ongoing mental health reform; • Extend the continuous care networks throughout Belgium; • Introduce a legally protected title for psychotherapists and reimburse psychotherapy sessions.

Chapter 1

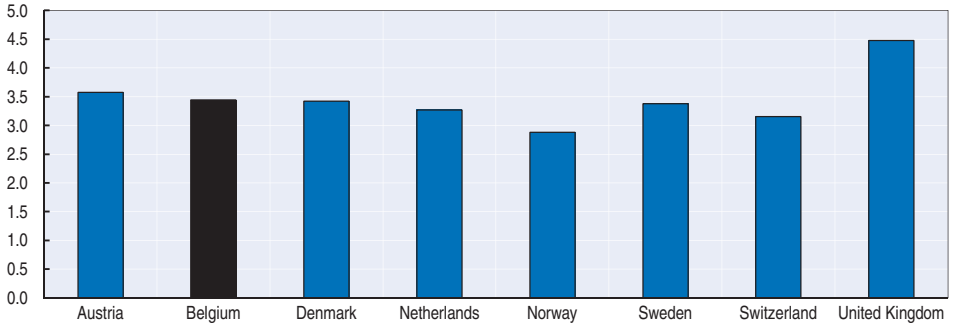
Mental health and work challenges in Belgium

Building on the findings in the recently published OECD report Sick on the Job?*, this chapter highlights the key challenges in the area of mental health and work and provides an overview of the current labour market performance of people with a mental disorder in Belgium compared to other OECD countries in terms of their employment and unemployment state, as well as their financial situation. The chapter also describes the role of the different government layers and the Belgian benefit system. It ends with a discussion of the advantages and challenges of the prominent role of the unemployment benefit system for people with a mental disorder in Belgium.*

Mental ill-health poses important challenges for the well-functioning of labour markets and social policies in OECD countries. These challenges have not been addressed adequately so far, reflecting widespread stigma and taboos. The total (direct and indirect) estimated costs of mental ill-health for society are large, reaching 3-4.5% of GDP across a range of selected OECD countries; 3.4% in Belgium (Figure 1.1).[1] Most of these costs do not occur within the health sector: indirect costs in the form of lost employment and reduced performance and productivity on-the-job are much higher than the direct healthcare costs. Based on comprehensive cost estimates in Gustavsson *et al.* (2011), indirect costs, direct medical costs and direct non-medical costs amount to 53%, 36% and 11%, respectively, of the total costs of mental disorders for society.

Figure 1.1. **Mental disorders are very costly to the society**

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



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

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

Introduction

According to the recently published OECD report *Sick on the Job? Myths and Realities about Mental and Work*, policy needs to respond more effectively to the challenges for improving the labour market inclusion of people with mental illness (OECD, 2012). More attention will need to be given to: mild and moderate mental disorders; disorders concerning the employed and the unemployed; and proactive measures to help them remain in work or find a job. This conclusion is drawn on the basis of a number of findings, including:

- Most people with a mental disorder are in work.

- Many people with a mental disorder want to work.
- Productivity losses at work through mental ill-health are large.
- People on unemployment or social assistance benefits often suffer from mental ill-health.
- Mental ill-health accounts for an increasing share of work incapacity, sickness and disability.
- Appropriate treatment can improve employment outcomes but under-treatment is pervasive.

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

Understanding the characteristics of mental ill-health is critical for devising the right policies. The key attributes of a mental disorder are: an early age at onset; its severity; its persistence and chronicity; a high rate of recurrence; and a frequent co-existence with physical or other mental illnesses. The more severe, persistent and co-morbid the illness, the greater is the degree of disability associated with the mental disorder and the potential impact on the work capacity of the person.[2]

A particular challenge for policy makers is the high rate of non-awareness, non-disclosure and non-identification of mental disorders – directly linked with the stigma attached to mental illness. However, it is not clear in all cases whether more and earlier identification would always improve outcomes or, instead, may contribute to labelling and the risk of stigmatisation. This implies that reaching people with a mental disorder is more important than labelling them and policies that avoid labelling might sometimes work best.

Sick on the Job? identifies two key directions for reform. First, policies should move towards preventing problems, identifying needs and intervening at various stages of the lifecycle, including during the transition into work, at the workplace, and when people are about to lose their job or to move into the benefit system. Second, steps should be taken towards integrating (or at least better co-ordinate) health, employment and, where necessary, other social services to combat such problems among people with mental ill-health.

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

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

Survey data with sufficient information on socio-economic variables, on the contrary, in most cases only include subjective information on the mental health status of the sample population. The existence of a mental disorder can be measured in such surveys through a mental health instrument, which consists of a set of questions on irritability, nervousness, sleeplessness, hopelessness, happiness, worthlessness, and so on. Such instruments allow the identification of people in good and poor mental health. For the OECD review on *Mental Health and Work*, the 20% of the population with the highest values on the respective instrument is classified as having a mental disorder in a clinical sense, with those 5% with the highest value categorised as "severe" and the remaining 15% as "mild and moderate" or "common" mental disorder.

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

For Belgium, data from three different surveys are used in this report: 1) The *Belgian Health Interview Survey* of 1997, 2001 and 2008; the mental-disorder variable is based on the GHQ-12 General Health Questionnaire, a screening tool for non-psychotic psychiatric disorders and a shorter version of the full GHQ-60 scale. 2) The *Eurobarometer* for 2005 and 2010: the mental disorder variable is based on a set of nine items: feeling full of life, feeling tense, feeling down, feeling calm and peaceful, having lots of energy, feeling downhearted and depressed, feeling worn out, feeling happy, feeling tired. 3) The *European Working Conditions Survey* (EWCS) for 2010: the mental disorder variable is based on a set of five items: feeling cheerful; feeling calm; feeling active; waking up fresh and rested; life fulfilling.

Notwithstanding the evident major costs of poor mental health, policies and institutions are not addressing mental ill-health sufficiently. Four core priority areas are identified in the report, which need urgent policy attention to minimise the serious adverse consequences of mental ill-health in the society. These include:

- *The importance of schools* to protect and promote the mental health of children and young people and of transition services to help vulnerable youth access the labour market successfully.

- *The importance of workplaces* to protect and promote mental health in order to prevent illness, reduced productivity at work and labour market exit.
- *The importance of employment services* for beneficiaries of long-term sickness, disability and unemployment benefits who are not working.
- *The importance of psychiatric services* delivered in ways that assist people of working age to either remain in work or to return to work.

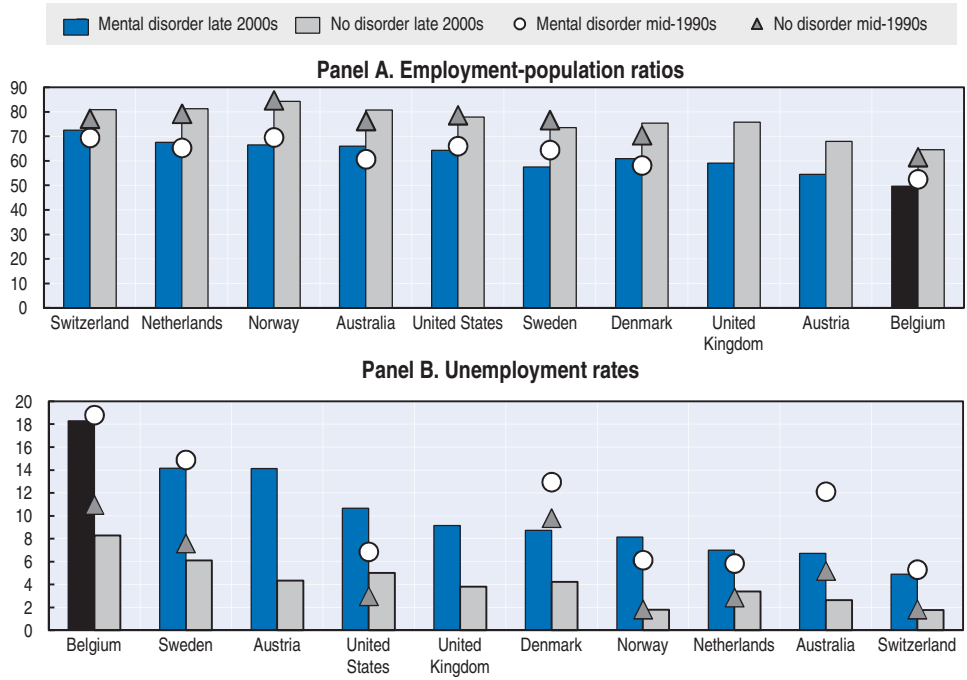
In the context of these challenges and priority areas for policy actions, the purpose of this report is to examine how policies and institutions in Belgium are addressing issues of mental ill-health and employment.

The structure of this report is as follows. The remaining sections of this chapter set the scene by: *i)* looking at some of the key outcomes for people with a mental disorder in Belgium; *ii)* discussing the responsibility of different government layers – *i.e.* federal, community and region – in regard to education, social, employment and mental health policies; and *iii)* describing the main systems catering for people with mental illness, especially the sickness and disability system and the public employment services. The other chapters of the report analyse the 'mental health and work' policy challenges that Belgium is facing by taking a life-cycle perspective. Chapter 2 looks at the period before a young person enters the labour market, *i.e.* the school and education system and the transition into the labour market. Chapter 3 analyses what is happening in the workplace and under the responsibility of the employer. Chapter 4 discusses the role of the different stakeholders of the sickness and disability benefit system, while Chapter 5 looks at the disability allowance system. Chapter 6 evaluates the unemployment benefit system and the final chapter, Chapter 7, discusses the role and contribution of the mental health system in each of these different phases.

Key trends and outcomes

As is the case in other OECD countries, people with a mental disorder in Belgium are less likely to be employed than people without mental health problems, with the employment rates being 50% and 65%, respectively (Figure 1.2, Panel A). Despite the general labour market improvement prior to the onset of the Great Recession in 2008, the employment rate of people with mental disorders in Belgium declined between 1997 and 2008, resulting in an increase in the employment gap compared with those without mental health problems from 9 to 15 percentage points (no data by mental health status are available for the post-2008 period).

Figure 1.2. **Labour market outcomes improved before the Great Recession in Belgium, except for people with a mental disorder, mid-1990s and late 2000s**



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

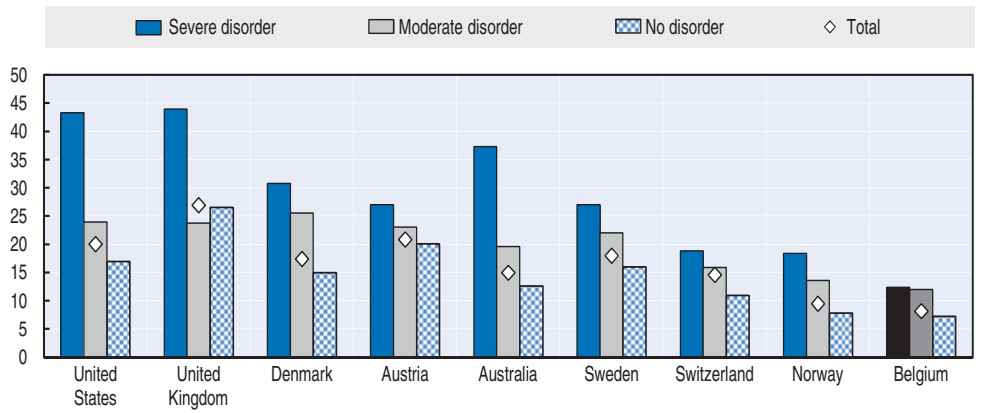
Unemployment rates for people with mental ill-health across OECD countries are consistently two to three times higher than for those without a mental disorder (Figure 1.2, Panel B). In Belgium, the unemployment rate for people with mental disorders reached 18% in 2008, compared with 8% for those without a mental disorder (no data by mental health status are available for the post-2008 period). Many people with mental disorders would thus like to work, but have difficulties in finding or retaining a job.

As a result of their under-performance in the labour market, people with a mental disorder are at a higher risk of relative income poverty than the average population. About 12% of people with severe or moderate mental disorders live in households with incomes below the poverty threshold, compared with 7% for their counterparts without mental health problems (Figure 1.3). Nevertheless, both the overall poverty risk and the difference in

poverty risks by mental health status are quite low in Belgium compared with other OECD countries.

Figure 1.3. **People with a mental disorder have a larger poverty risk**

Poverty risks[a] for people with a severe, moderate or no mental disorder, latest year available

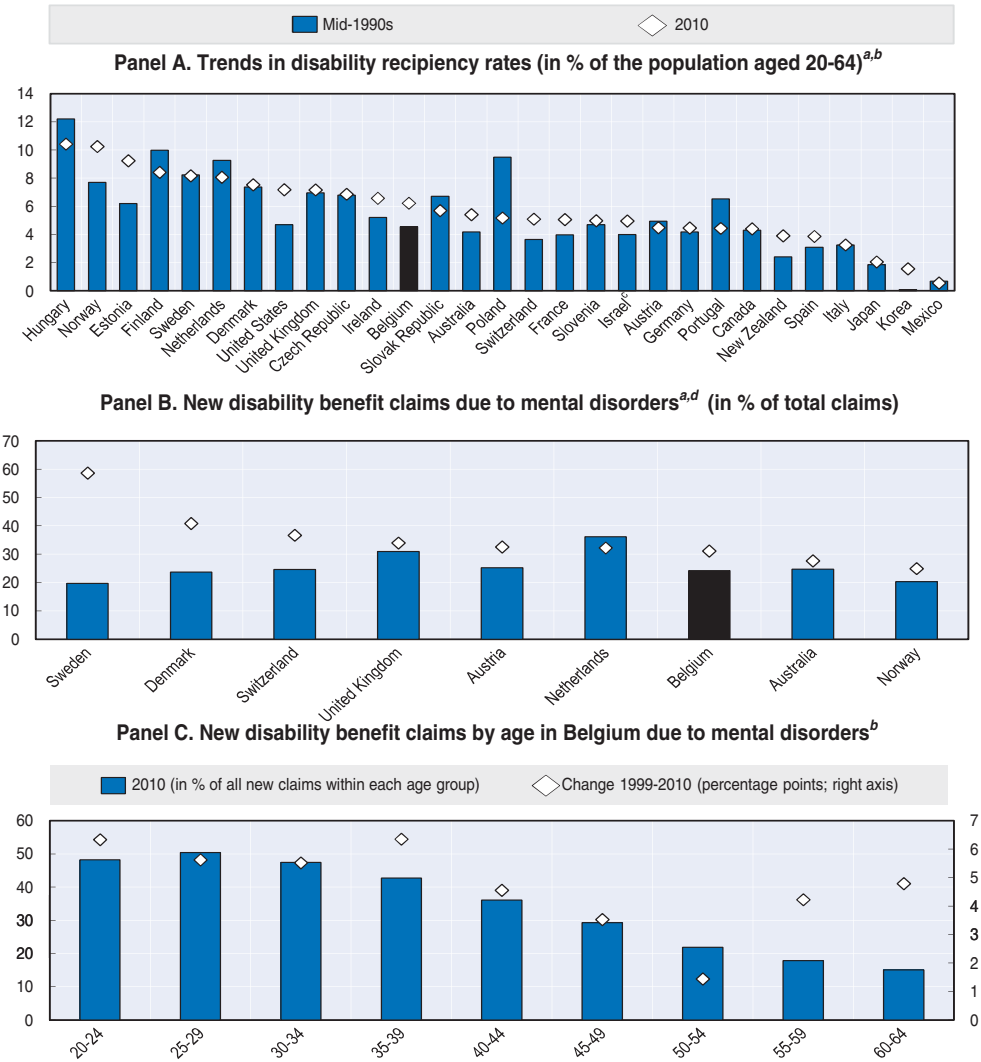


a. The percentage of people living in households with incomes below the low-income threshold (defined as 60% of median income).

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

At the same time, the absolute number of disability recipients and the share of mental disorders among new disability benefit claims are both increasing rapidly. By the late 2000s, 6.2% of the population aged 20-64 in Belgium was receiving sickness or disability benefits, up from 4.6% in the mid-1990s (Figure 1.4, Panel A). The increase in disability benefit claims in Belgium is to a large extent due to the increase in the pension age for women from 60 in 1997 to 65 in 2009 (Jousten *et al.*, 2011). Yet, more importantly and in line with trends in many OECD countries, an increasing share of new disability benefit claims are related to mental ill-health, reaching nearly one third of all new claims in 2010 in Belgium (Figure 1.4, Panel B). Worryingly, the increase is largest among younger people (aged 20-39 years), where the share of mental health problems among new claims within that age group attained nearly 50% in 2010 compared with about 20% among the age group 50-64 (Figure 1.4, Panel C).

Figure 1.4. **Fast increase in disability benefit claims due to mental disorders**



a. Norway includes the temporary benefit in Panel A, but not in Panel B.

b. Data refer to 2005 for Luxembourg, to 2007 for Canada, France, Italy and Poland, to 2008 for Australia, Austria, Japan, Korea and Slovenia and to 2009 for Germany, Mexico, New Zealand, Norway, the Slovak Republic, the United Kingdom and the United States.

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

d. Belgium, the Netherlands and Sweden include mental retardation, organic and unspecified disorders.

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

Despite the increasing disability due to mental disorders, there is ample epidemiological and clinical empirical evidence that the prevalence of mental disorders has not increased in OECD countries. The recently published OECD report *Sick on the Job?* (OECD, 2012) concludes that the shift in the structure of new disability claims towards mental disorders is partly the consequence of a better awareness of such disorders and the often false interpretation that such disorders would cause high and permanent work incapacity. At the same time, job requirements in the workplace have increased or changed, making it increasingly difficult for workers with mental health problems to perform adequately.

Description of the social protection system in Belgium

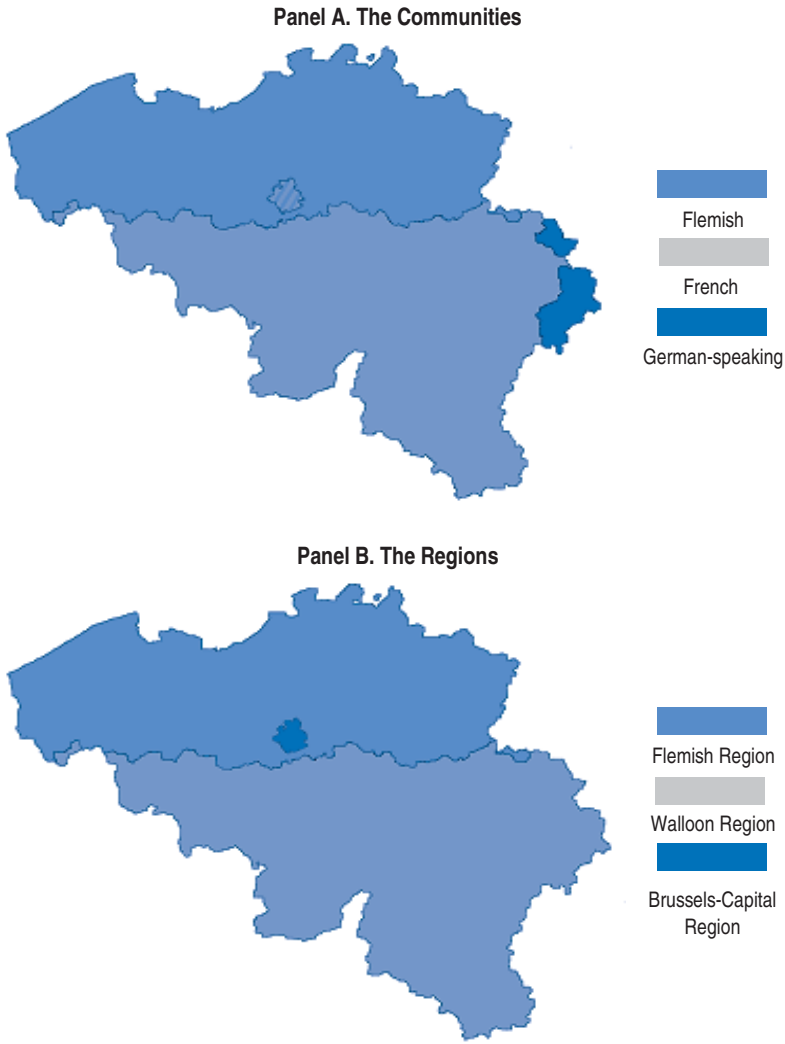
The structure of the federal state

Belgium is a federal state composed of three Communities, *i.e.* the Flemish Community, the French Community and the German-speaking Community (Figure 1.5, Panel A), and three Regions, *i.e.* the Brussels-Capital Region, which is officially bilingual, the Flemish Region, which is Dutch-speaking, and the Walloon Region, which is French and German-speaking (Figure 1.5, Panel B).

The main federal institutions are the federal government and the federal parliament (with a Chamber of Representatives and a Senate), while the Communities and Regions each have their own government and parliament. Yet, the Flemish Region transferred all its constitutional competences to Flemish Community immediately after its establishment in 1980, to facilitate the co-operation between the departments responsible for community and regional matters. There is thus only one government and one parliament in Flanders.

The three language Communities enjoy powers over various policy areas, such as family and child support, education, culture, and certain aspects of health care. The three Regions focus primarily on considerations of an economic or local nature such as employment, public works, agriculture, land-use planning and the environment. The sixth institutional reform of 2011 (to be implemented after 2014) involves a further decentralisation of resources and policies to the Regions and Communities, which are assigned more decision-making powers in the areas of labour market, family benefits and others (issues relevant for this report will be discussed in the respective sections). Social security, on the other hand, remains a core activity of the federal level. The details and exact implementation of the latest reform are still under discussion.

Figure 1.5. **The structure of the federal state Belgium**



Note: This map is for illustrative purposes and is without prejudice to the status of or sovereignty over any territory covered by this map.

Source: Adapted from wikipedia, *http://en.wikipedia.org/wiki/Communities,_regions_and_language_areas_of_Belgium*.

Social protection in Belgium

Social protection in Belgium can be classified into two broad categories: *i) social security*, *i.e.* medical care, sickness and disability insurance benefits, pensions, unemployment insurance, family benefits, work accidents insurance, professional diseases insurance, and annual vacation; and *ii) social assistance*, *i.e.* integration income, guaranteed income for the elderly, disability allowances and guaranteed family allowances. Within the social security system, three broad regimes for wage-earners, self-employed and civil servants can be distinguished, with substantial differences in coverage and the degree of social protection. A discussion of the social insurance systems for the self-employed and civil servants is beyond the scope of this report; the reader is referred to the overview of Belgian social security published by the Federal Public Service for Social Security (2011) for more details.

Public health insurance is organised and co-rdinated at the federal level by the National Institute for Sickness and Invalidity Insurance (RIZIV/INAMI). Unlike in most other OECD countries, the same institution is responsible for both sickness benefits (up to one year) and disability benefits (beyond one year), and all disability beneficiaries necessarily go through one year of sickness benefits (see Box 1.2 for an overview of the eligibility conditions and benefit levels). At the operational level, the National Institute for Sickness and Invalidity Insurance relies on a series of accredited mutual insurance providers that act as the interface between the health insurance system and the insured – with financial balancing mechanisms in place for compensating inherently different risk pools between providers. Beyond their role as paying agents on behalf of the National Institute for Sickness and Invalidity Insurance, the mutualities are also the key gatekeepers in the access to sickness and disability benefits.

Besides the sickness and disability benefits paid by the National Institute for Sickness and Invalidity Insurance, disabled people with a reduced earning capacity are eligible for two types of non-contributory disability allowances of the Federal Public Service for Social Security (see Box 1.2 for the benefit levels and eligibility criteria). The "income replacement allowance" is mainly for people who have never worked or not long enough to fulfil the disability insurance contributory requirements, but can also be paid on top of other working-age benefits if the household income is below a certain threshold. The "integration allowance" compensates people for the additional difficulties they encounter in daily activities due to their disability. Both types of disability allowances are granted independently of each other and can be combined with other benefits.

The payment of unemployment benefits is organised at the federal level by the National Employment Office (RVA/ONEM), while the job placement and active labour market policies are fully in the hands of the regional public employment services – VDAB (*Vlaamse Dienst voor Arbeidsbemiddeling en Beroepsopleiding*) in Flanders, Actiris in Brussels and Forem in Wallonia) – requiring an important need for co-ordination. In addition, trade unions play an important operational role as official paying agents for their members, while non-unionised unemployed people receive their benefits from yet another public institution, *i.e.* the Auxiliary Fund for the Payment of Unemployment Benefits. Benefits are computed based on capped past earnings and have similar initial payment rates as disability benefits (see Box 1.2.), and they are payable indefinitely. Continued receipt of unemployment benefits is dependent on meeting job-search and availability conditions; these conditions, however, were not universally applicable to all beneficiaries (*e.g.* unemployed people older than 50 were exempted from such requirements until end-2011).

Box 1.2. **Eligibility conditions and benefit rates for selected Belgian benefit schemes**

Unemployment benefits

To be entitled to unemployment benefits, a job seeker must have worked for more than a year during 27 months – the employment requirement increases with age, *e.g.* a worker aged 36-49 years must have worked 468 days during 27 months – and people who become voluntarily unemployed can be temporarily excluded from receiving benefits for a period of 4-52 weeks. Eligibility is not entirely based on a contributory history, as high-school graduates can enter the unemployment rolls without ever having contributed to the system. The waiting periods for graduates are 155, 233 and 310 days for the age groups under 18, 18-25 and 26-29 respectively.

Sickness and disability insurances

To be eligible for sickness and disability benefits, a wage earner must have worked at least 120 days (paid vacation and sickness leave are counted as actual work) during a period of six months prior to obtaining benefits and must satisfy minimum contributory requirements. A medical-economic definition determines eligibility for sickness and disability benefits: a worker has to suffer from a loss of earnings capacity of 66% or more as a result of injuries or functional difficulties, or aggravation of these. Any job a person did, or could possibly do according to his/her qualifications and experience, is considered. However, if the illness shows a favourable evolution, only the usual occupation is taken into account during the first six months to determine the earnings capacity loss.

Box 1.2. **Eligibility conditions and benefit rates for selected Belgian benefit schemes** *(cont'd)*

Disability allowances

Income replacement allowances and integration allowances are non-contributory benefits for disabled people. A person is entitled to income replacement allowances if he/she is unable to earn more than one third of what a healthy person can earn by working. The integration allowance is determined by the reduction of autonomy as a result of the disability, which is evaluated using a medical-social scale. Both disability allowances are means-tested and depend on the family situation. The income replacement allowance and integration allowance can be granted together or separately, and can be combined with other benefits.

Benefit rates and maximum benefit levels, 2011

	Person with dependants[a]	Single person[b]	Cohabitant[c]
	Benefit rates in percentage of previous earnings		
Unemployment benefit			
1st year	60	60	60
2nd year (first three months)	60	55	40
after first three months of 2nd year	60	55	lump sum[d]
Sickness and disability insurance			
Sickness benefit	60	60	60
Disability benefit	65	60	40
	Maximum benefit amounts per month (EUR)		
Disability allowance			
Income replacement allowance	1007	755	504
(as a % of the average wage)	(30%)	(22%)	(15%)
Integration allowance	828	828	828
(as a % of the average wage)	(25%)	(25%)	(25%)

a. A worker who lives with one or more persons who do not have a professional or alternative income.

b. A worker who lives alone.

c. Worker who neither lives alone nor has dependents; cohabitants are people who live together in the same household and share common household issues.

d. The lump-sum allowance was EUR 465 per month on 1 July 2011 (equal to about 14% of the average wage). If the recipient has completed 20 years of professional service or has 33% of permanent unemployability, the benefit rate is 40% of previous earnings. In addition, under certain conditions, a cohabitant can see his unemployment benefit suspended if the duration of unemployment exceeds 1.5 times the regional average for his age group and gender.

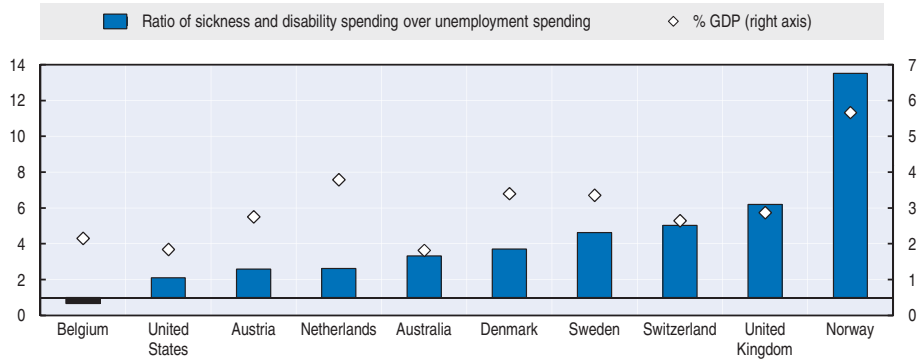
Source: Belgium 2010, Benefits and Wages: OECD Indicators, www.oecd.org/els/social/workincentives, and the Belgian National Institute for Sickness and Invalidity Insurance.

The importance of the unemployment benefit system for people with a mental disorder

Not all people with a mental disorder who are unable to find a job end up on disability benefits; many are dependent on other types of working-age benefits, such as unemployment benefits or social assistance. In contrast to most other OECD countries, the overall expenditure on disability and sickness in Belgium is lower than spending on unemployment, (Figure 1.6; see Appendix for more detailed statistics on all OECD countries). There are also more people with a moderate mental disorder on unemployment benefits in Belgium than there are on disability benefits and a relatively large share of those with a severe mental disorder receives unemployment benefits, while this group would typically receive disability benefits in other OECD countries (Figure 1.7).

Figure 1.6. **Belgium spends less on disability and sickness than on unemployment**

Expenditure on disability and sickness in percentage of GDP and as a ratio of unemployment spending, 2009



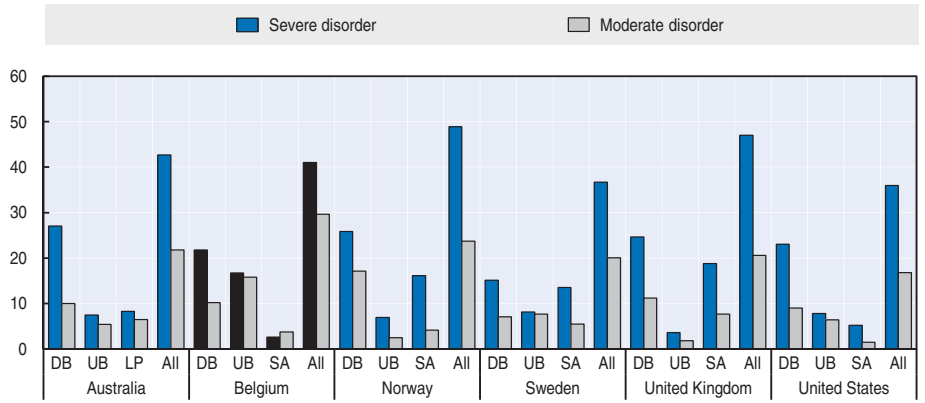
Source: *OECD Social Expenditure Database (SOCX), www.oecd.org/els/social/expenditure.*

The prominent role of the unemployment benefit system for people with a mental disorder in Belgium is related to a number of factors. First, the time-unlimited unemployment benefit system renders the more stringent disability benefit system less attractive to people with mental ill-health. Unemployment beneficiaries have the obligation to actively look for a job and can be suspended if they do not co-operate, but mental ill-health is a valid reason for refusing suitable job offers and caseworkers often find it socially unacceptable to suspend long-term beneficiaries with multiple problems (among which often mental health problems) whom they cannot activate (see Chapter 6 for a discussion). Not all unemployed people with mental health problems are eligible for disability benefits (in particular those with moderate mental disorders) and even if they are, the transfer onto

disability benefits is long and people may temporarily end up without benefits. Second, disability beneficiaries are regularly controlled for health improvements (with the frequency decided by the mutuality doctor, see Chapter 4 for a discussion), while this is not necessarily the case in the unemployment benefit system. As such, people with a mental disorder may actually perceive the unemployment benefit system as more permanent and secure than the disability benefit system. Third, there are no strong financial incentives for unemployment beneficiaries with (mental) health problems to apply for a sickness and disability benefit as the benefit levels are more or less comparable (see Box 1.2 above). Nevertheless, since November 2012, unemployment benefits have become more degressive and less generous than disability benefits and may give people with health problems more incentives to apply for sickness and disability benefits.

Figure 1.7. **Many people with a mental disorder receive unemployment benefits in Belgium**

Proportion of people receiving a disability benefit (DB), unemployment benefit (UB), social assistance payment (SA) or lone-parent benefit (LP), by mental health status, distribution in the latest year available



Note: Disability benefit includes a variety of incapacity-related benefits. In Belgium, for instance, it includes sickness benefits, disability insurance benefits and disability allowance benefits.

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

The high proportion of people with a mental disorder on unemployment benefits has certain advantages, but also requires more attention to the needs

of this group. On the one hand, people with a mental disorder receiving unemployment benefits remain in close contact with the labour market and can therefore be more easily activated. On the other hand, if public employment centres (PES) have no experience in dealing with mental health problems or do not have the (human) resources to devote more attention to this group of beneficiaries, it is unlikely that they will succeed in activating them. Also, stronger activation pressure by the PES could give people incentives to move onto disability benefits. Close co-operation between the PES and the mutualities will therefore be necessary to improve labour market outcomes of people with mental health problems, an issue which will be discussed in detail in Chapters 4 and 6.

Conclusion

The following key facts emerge from the evidence available:

- Labour market conditions improved since the mid-1990s up to the start of the Great Recession, but not for people with mental health problems.
- The increase in disability benefit claims over the past decades is largely due to an increase in the pension age for women. The share of mental disorders among new disability claims is, however, rising rapidly, especially among beneficiaries aged under 40.
- Sickness and disability benefits are integrated into one single system. Tackling sickness absence early on can thus be a very effective strategy for minimising the inflow into disability benefits.
- The unemployment benefit system plays a prominent role for people with a mental disorder upon job loss. Contrary to most other OECD countries, spending on unemployment is higher than spending on sickness and disability and there are more people with a moderate mental disorder on unemployment benefits than on disability benefits. The advantage is that people with mental health problems losing their job remain closely attached to the labour market.

Notes

1. Mental disorders, as defined in this report, exclude intellectual disabilities which encompass various intellectual deficits, including mental retardation, various specific conditions such as specific learning disability, and problems acquired later in life through brain injuries or neurodegenerative diseases like dementia. Organic mental illnesses are also outside the scope of this report.

2. The diagnosis also matters, but mental illness of any type can be severe, persistent or co-morbid. The majority of mental disorders fall in the category mild or moderate, including especially depression and anxiety disorders.

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Chapter 2

The Belgian education system

This chapter assesses the capacity of the Belgian education system to support vulnerable children and youth with a mental disorder during their school career and transition into the labour market. It discusses strategies to prevent mental health problems in schools and the effectiveness of the school system in dealing with students with mental disorders. It also reviews policies directed at early school leavers who are at a greater risk of developing a mental disorder and, finally, examines the effectiveness of employment programmes to boost labour demand for vulnerable youth.

Childhood and adolescence are crucial periods for the promotion of good mental health and the prevention of mental disorders. An extensive literature shows that both biological factors and adverse psychosocial experiences during childhood influence child and youth mental health (see OECD, 2012a, for a discussion). Three-quarters of all mental disorders have their onset by the age of 24, one-quarter already by the age of 7 (Kessler *et al.*, 2005). Most of these young people have a mild or moderate mental illness and can expect a productive life. Yet, their mental health problems can negatively affect their education, and consequently their social and professional life as adults. At the same time, there is a considerable lack of awareness, non-disclosure and under-treatment among adolescents and young adults, with the gap before the first treatment of a mental illness being about 12 years on average (Kessler and Wang, 2008). Therefore, the education system has a potentially important role to play in early identification and accompaniment of children with mental health issues (see Box 2.1 for a short overview of the Belgian education system).

Box 2.1. **Education policy is a community matter in Belgium**

In Belgium, education policy is a community matter and the institutional set-up varies across the three language communities. Primary and secondary education is free of charge and schools are financed or funded by the government. There are three types of educational institutions: *i)* community schools (funded by the language Communities and neutral with respect to religious, philosophical or ideological convictions); *ii)* publicly-run schools (subsidised and organised by provinces and municipalities); and *iii)* "free" private schools (mainly Catholic schools, but also some Jewish and Protestant schools, as well as non-confessional schools, *e.g.* Steiner and Freinet schools).[1]

Belgium is one of the few OECD countries with compulsory education up to the age of 18. Until the age of 16, education is full-time; afterwards students can opt for a combination of part-time education and working. After six years of primary education and two years of secondary education, students may choose between four full-time and two part-time tracks. The full-time tracks are offered by secondary schools and include general, technical, artistic, and vocational education. The part-time options in the Flemish Community include part-time vocational secondary education offered by part-time secondary schools, apprenticeships offered by *Syntra* and part-time training programmes. In the French Community, the combination of part-time education and working is offered by the *Centres d'Education et de formation en Alternance* (CEFA).

1. In Flanders, the subsidised private schools are the largest both in number of schools and pupils, while in the French Community, these schools are roughly equal in size to community schools.

Strong focus on special education

Children with special education needs due to severe disabilities are typically sent to the special education system in Belgium, unlike in many other OECD countries, where these children often remain in the mainstream school system or in special classes within a mainstream school to promote their social integration. Data from the European Agency for Development in Special Needs Education show that 83% and 99% of the students with special needs go to the special education system in the Flemish Community and French Community, respectively (Table 2.1). While these data cover students with all types of disabilities, administrative data for 2003 collected by the OECD illustrate that these findings equally apply for children with serious behavioural or emotional disorders or serious learning difficulties in Belgium (Figure 2.1). Note that the low share of children with special education needs in mainstream schools in Belgium is not due to a lower identification; the percentage of students with special education needs in the total number of students is similar to other OECD countries (Table 2.1) and has been rising continuously over the past two decades.

Table 2.1. **Belgium has a strong focus on special education for children with disabilities**

Number of students with special needs and the importance of the special education system, 2008-09[a]

	Total number of students	Students with special needs				
		Number	% of total students	% in special education	% in segregated special classes in mainstream schools	% in mainstream schools
Austria	802 519	28 525	3.6%	41%	3%	55%
Belgium - Fl. Community	863 334	57 261	6.6%	83%	-	17%
Belgium - Fr. Community	687 137	30 993	4.5%	99%	-	1%
Denmark	719 144	33 733	4.7%	38%	56%	6%
Netherlands	2 411 194	103 821	4.3%	62%	-	38%
Norway	615 883	48 802	7.9%	4%	11%	85%
Sweden[b]	906 189	13 777	1.5%	4%	96%	-
Switzerland[b]	777 394	41 645	5.4%	39%	61%	-
United Kingdom	9 297 319	316 340	3.4%	34%	7%	59%

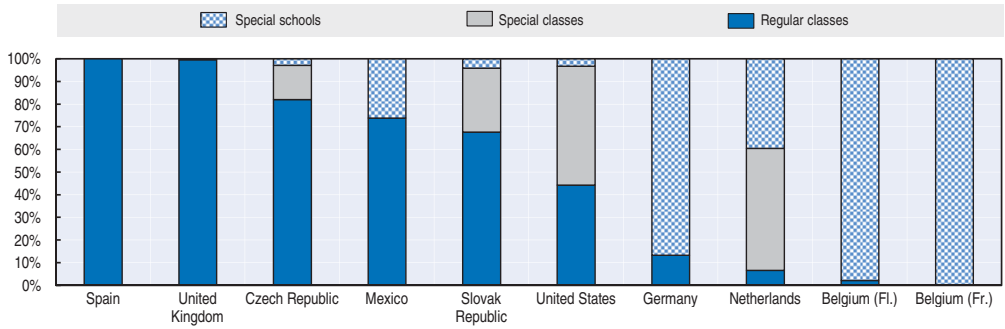
a. The data for the Netherlands and Norway refer to the school year 2009-10, and those of the Flemish Community in Belgium to the school year 2010-11.

b. Data on students with special education needs who are fully included in mainstream classes are not collected in Sweden and Switzerland.

Source: OECD calculations based on data from the European Agency for Development in Special Needs Education (*www.european-agency.org*).

Figure 2.1. **Nearly all children with severe mental disorders are in special schools in Belgium**

Share of students with severe behavioural or emotional disorders or severe learning difficulties receiving additional resources by, type of school or class, 2003



Note: The data only cover children with severe behavioural or emotional disorders, or specific difficulties in learning, and not children with disabilities or impairments viewed in medical terms as organic disorders attributable to organic pathologies (*e.g.* in relation to sensory, motor or neurological defects).

Source: OECD (2007), *Students with Disabilities, Learning Difficulties and Disadvantages,* Figure 6.24, OECD Publishing, Paris, *http://dx.doi.org/10.1787/9789264009813-en*.

Special schools have the advantage of providing specialised and individualised support in a protected environment. In particular, Belgium has a rather low student-per-teacher ratio in the special education system in comparison with other OECD countries (OECD, 2007a). However, the disadvantage of such segregation is a risk of further marginalisation, hence jeopardising their social integration and a successful transition into the regular labour market later in life.

In the French Community, a new law from 2009 facilitates the integration of children with special needs into mainstream schools with the support from the special education sector depending on the child's needs, such as a specialised teacher, nurse, speech therapist, etc. Only since very recently can students with severe mental health problems apply for integration in mainstream schools. Yet there is very little support targeted at their needs available (such as a child psychologist or psychotherapist). So far, integration into the mainstream school system remains very limited: only 1.5% of all children with special needs (not restricted to mental disorders) were reintegrated in mainstream schools in 2009-10.

In the Flemish Community, an increasing share of children with special education needs are being integrated in mainstream schools (17% in the school year 2010-11), though still significantly lower than in some other OECD countries (Table 2.1). For children with severe behavioural or

emotional disorders or learning difficulties, it is particularly difficult to receive support in the mainstream school system. To be eligible for support measures, the child first has to go to a special school for at least nine months and once back in the regular school system, the support measures are restricted to a maximum of one year (except for kindergartens).

Comprehensive services in the school environment

In the Flemish education system (both in the mainstream school system and special education), two separate but complementary care units have been created in order to cover the continuum of basic to specialised care for school-aged children and adolescents.

The first unit, the so-called "internal care structure" (*interne leerlingenbegeleiding*), operates from within the school. Each school receives funding to exempt teachers from (part of) their teaching duties or to hire specialised staff (a psychologist, pedagogue, medical staff or social worker) so they can provide extra care for pupils in need (so-called "care teachers"). All primary schools are obliged to have a three-level care policy consisting of co-ordination at the school level, coaching and support for teachers, and student guidance, but they are allowed to fill in the levels according to their needs. In some schools, the care teacher primarily engages in one-to-one interventions (*e.g.* giving pupils the opportunity to talk about their problems at school or at home). In other schools, the "care teacher" focuses more on group-based approaches (*e.g.* implementation of bullying prevention programmes) or devising new policies (*e.g.* healthy school policy).

A recent evaluation shows that the "care policy" with a central role for the teacher as primary actor has become widely accepted in primary education in Flanders as a result of a range of policy initiatives and increased spending from the Flemish Government (Struyf *et al.*, 2012). Primary schools have, on average, the full-time equivalent of 0.6 care teacher, with the 25% largest schools employing 0.75 to 1 full-time care teacher. In addition, schools with at least 10% of their pupils (25% in secondary education) belonging to a risk group (*i.e.* foreign language spoken at home, low-educated mother, or receiving a school subsidy) receive additional resources equivalent to one to two full-time teachers.[1] The same study points out, however, that secondary schools typically have a much less developed internal care structure as the issue has received much less attention and resources from the government. In international comparison, Belgium has on average smaller class sizes, but much less pedagogical support staff per teacher in lower secondary than in most other OECD countries (Table 2.2).

Table 2.2. **Belgium has relatively little pedagogical support for teachers**

Average class size and staff-to-teacher ratios in lower secondary education, 2010

	Average class size (lower secondary education only)		Ratio of teachers to number of personnel for pedagogical support	
Country	Mean	(Standard error)	Mean	(Standard error)
Australia	24.6	(0.20)	8.3	(0.61)
Austria	21.1	(0.14)	24.1	(1.08)
Belgium (Flanders)	**17.5**	**(0.27)**	**20.5**	**(1.63)**
Denmark	20.0	(0.22)	9.1	(0.97)
Estonia	20.5	(0.32)	10.4	(0.69)
Hungary	20.2	(0.57)	7.3	(0.69)
Iceland	18.6	(0.02)	5.7	(0.60)
Ireland	21.9	(0.18)	15.8	(1.06)
Italy	21.3	(0.16)	20.4	(3.22)
Korea	34.6	(0.43)	14.0	(1.12)
Mexico	37.8	(0.55)	7.9	(0.68)
Norway	21.4	(0.29)	7.0	(0.41)
Poland	20.8	(0.27)	9.4	(0.56)
Portugal	21.3	(0.21)	10.8	(1.64)
Slovak Republic	21.1	(0.26)	14.3	(1.15)
Slovenia	18.8	(0.18)	18.3	(1.16)
Spain	21.7	(0.26)	19.0	(0.91)
Turkey	31.3	(0.75)	22.2	(2.53)
Average	***23.0***		***13.6***	

Note: These data are means of characteristics of the schools where lower secondary teachers work. The education provision in these schools may extend across ISCED (International Standard Classification of Education) levels (*e.g.* in schools that offer both lower and upper secondary education) and therefore may not apply only to teachers or students of lower-secondary education.

Source: OECD (2010), *Creating Effective Teaching and Learning Environments: First Results from TALIS*, OECD Publishing, Paris, *http://dx.doi.org/10.1787/9789264068780-en*.

The second unit, *i.e.* the student guidance centres (*Centra voor Leerlingenbegeleiding* – CLBs), assists schools in four core domains, *i.e.* learning strategies, educational career planning, psychosocial functioning and preventive health care, with multidisciplinary teams of psychologists (typically the director of the centre), doctors, nurses, social workers and pedagogues. The CLB centres also perform regular medical check-ups and as such are structurally linked to both the Flemish Department for Education and the Flemish Department for Welfare, Public Health and Family.[2] The centres operate based on the principle of universal surveillance for all students, on the one hand, and individualised, multidisciplinary and intensive guidance for students with greater needs, on the other hand. The

work of the centres is mainly demand-driven and they intervene after a request from a student, parent or school, but they also play a key role in school drop-out prevention, access to special and integrated education and regular medical check-ups. Besides giving information, support and guidance, the centres typically have a good overview of external services to which they can refer people if they cannot solve the issue themselves.

A recent evaluation of the CLB centres by Vermaut *et al.* (2009) revealed that practices vary greatly across centres and that they not always have enough staff to fulfil all of their tasks. For the school year 2010-11, CLB caseworkers were responsible for about 400 students on average (Vlaamse Overheid, 2011), and 91% of the CLB caseworkers (fully) agreed that the work pressure has increased since 2000 (Vermaut *et al.*, 2009).[3] Due to a lack of time, caseworkers are continuously confronted with the choice between focusing on preventive actions and dealing with more immediate requests for assistance and interventions. As there is an increasing demand from schools, parents and students for support from the CLB centres (in particular with respect to psychosocial problems; see Vermaut *et al.*, 2009), centres tend to undertake little prevention or early detection. Individual and curative support is also more rewarding for caseworkers than preventive measures as the effects are visible in the short term. Besides, long waiting lists for external services, in particular in the mental health sector,[4] increase the workload for CLB caseworkers as they continue supporting the students until they get access to specialised care. The co-operation between schools and the centres is not always optimal as schools are sometimes not aware of their own role or the areas in which they can request support for the centres. Finally, low-educated and migrant students and their parents are often badly informed, while their need for support is likely to be higher.

In the French Community, several players support schools in their extra-curriculum tasks in dealing with students with special needs. The Psycho-Medical-Social (PMS) centres have a similar role as the CLB centres in the Flemish Community and also work with a multidisciplinary team. Yet, regular medical check-ups are the responsibility of a separate service, *i.e. Service de Promotion de la Santé à l'École* (PSE), while the major actors in school drop-out prevention are the School Intermediation Services (*Service de la Médiation Scolaire*) and Mobile teams (*Équipes Mobiles*). Co-ordination and co-operation between the different services is limited, however, and none has the authority or recognition to take up a leading role as the CLB centres do in the Flemish Community. On several occasions, an attempt was made to merge the PMS and PSE centres, but so far without success, mainly because the PMS centres depend on the Department of Education (community matter) and are headed by psychologists, while the PSE centres depend on the Department of Local Authorities, Social Action and Health (regional matter) and are headed

by medical doctors.[5] Despite their more limited role, the PMS centres have a comparable budget as the CLB centres, *i.e.* about EUR 114 and EUR 133 per student, respectively, in 2009.[6]

Interesting initiatives to prevent school drop-out

As students are legally obliged to attend school until the age of 18, the Departments of Educations of the different language Communities carefully screen school enrolment and attendance through an electronic registration system. Parents of children who are not enrolled in a school on the third school day are contacted and, if there is a lack of co-operation, the case is referred to the public prosecution office. In the Flemish Community, 99.8% of all school-age children are enrolled in a school (Vlaams Ministerie van onderwijs en vorming, 2010).

Repeated absence from school is closely monitored to avoid school drop-out and has received considerable attention from policy makers over the past few years.[7] In the Flemish Community, the school is obliged to inform the CLB centre after 10 half days of unauthorised absence (or earlier if the school deems it necessary) and the CLB centre is obliged to start with guidance for the student, while in the French Community, schools are compelled to contact the parents and students by means of a registered letter at the latest after 20 half days of unauthorised school absence. Different services can assist schools in the French Community (*e.g. Service de la Médiation Scolaire*, *Équipes Mobiles*, or *Service d'Aide à la Jeunesse*), but there is no mandatory signalling mechanism. Caseworkers work together with the students, school and parents to find a solution to the underlying problem and bring, if needed, the student in contact with other services (such as welfare or health services). After 30 half days of unauthorised absence, the Department of Education of the respective language Community has to be informed. At that moment, further legal action can be taken and the parents are sanctioned as they have to reimburse their school subsidy. This was the case for 1.4% of the secondary-school population in the school year 2009-10. According to schools, low motivation and school fatigue are the most important reasons for repeated absences from school, but also poor well-being at school (related to the school climate, student-teacher relations, bullying, etc.) and a problematic family situation are other key factors (Vlaams Ministerie van onderwijs en vorming, 2010). Statistics from the Flemish province Antwerp show that about 14% of all secondary school students were absent unauthorised for 10 half days or more in 2009-10 (Vlaams Parlement, 2011).

To prevent school drop-out by students with more severe behavioural problems – from the OECD report *Sick on the Job?* (OECD, 2012a) we know that youth with mental disorders are more likely to leave school

prematurely – all three Communities have a system in place to take students temporarily out of the school environment (for days, weeks or even months), called *Accrochage Scolaire* in the French Community and *Time-out* in the Flemish and German Communities. A team of pedagogues and social workers works with the students to address their problems – often multiple behavioural problems affecting their participation in school and social life – and motivate them to return to school. Also the parents, school and student guidance centres are involved. Despite the fact that these programmes are likely to be often confronted with youth with mental health problems, very few organisations have a (child) psychologist in their team. Even so, the *Accrochage Scolaire* and *Time-out* programmes would be ideally placed to address mental health problems early on, without the necessity to label the students and potentially reinforcing their problems.

Programmes consist of both individual activities and group activities to understand and work on the student's personality, ranging from discussion sessions and adventure weekends, to workshops on theatre, cinema, music and writing. In the French Community, the maximum duration of such programme is three months, renewable once. In the Flemish Community, a short programme of a few days exists for students who show the first signs of problems and for which the school does not have an immediate solution. The longer programme (several weeks) focuses on students who cause significant problems at schools or who are completely de-motivated. In principle, a student is referred by the CLB or PMS centres, but schools can also directly send students for a short programme. Participation is voluntary, but often pressure on the student to participate is high. After the programme, the caseworker remains available in case there is a problem and for the longer programmes, a follow-up meeting is organised with all involved partners after three months.

The programmes started as pilot projects (dating back to 1995 in Brussels), but since 2006 for the Flemish Community and 2009 for the French Community, a legal framework with permanent funding from the respective Departments of Education is in place. In the Flemish Community, the Department for Welfare, Public Health and Family co-finances the long *Time-out* projects, since school drop-out is often a signal for underlying, more complex problems and requires co-ordination and close co-operation with the health care and welfare sector. In each Community, there are about 15 non-profit organisations offering such programmes. As funding is provided through various sources, there are no statistics available on the total number of participants and/or the outcomes of the programmes. The Flemish Government finances 645 short and 182 long *Time-out* projects per year and anecdotal evidence suggests that nearly an equal number of long

Time-out projects are financed through other sources, such as cities, municipalities and foundations (*e.g.* King Baudouin Foundation).

Nevertheless, the share of unqualified school leavers in Belgium is not very different from many other OECD countries, despite the comparatively long compulsory school age. In 2008, 14% of 20-24 year olds did not have an upper-secondary qualification and are not in education compared with 17% in the OECD area on average (OECD, 2010b). Different factors play a role in school drop-out: socio-economic background, migration background, learning difficulties and personal problems, as well as a problematic education path – including repeating a year (35% of all 15-year-olds in Belgium repeated at least one year, much higher than the OECD average of 13%; OECD, 2012b), frequent school absences, etc. (Glorieux *et al.*, 2009).

To improve co-ordination between and co-operation among the different providers of youth services, Flanders set up a platform in 2005 called Integral *Youth Help*. The platform attempts to address the inter-sectoral barriers to co-operation in order to make the different systems (welfare, health, legal, education, etc.) more client-oriented. Since 2005, youth legal rights have been harmonised across the systems and a database mapping all local services in a comparable way has been set up.[8] *Integral Youth Help* also intends to replace the different entry gates to specialised services by one inter-sectoral entry gate (*i.e.* same procedure irrespective of the entry point), and to set up an integrated information system. The platform has ambitious goals, but the system is very complex and so far very little has happened in reality; there is still a long way to go to have inter-sectoral co-operation (Van Tomme *et al.*, 2011).

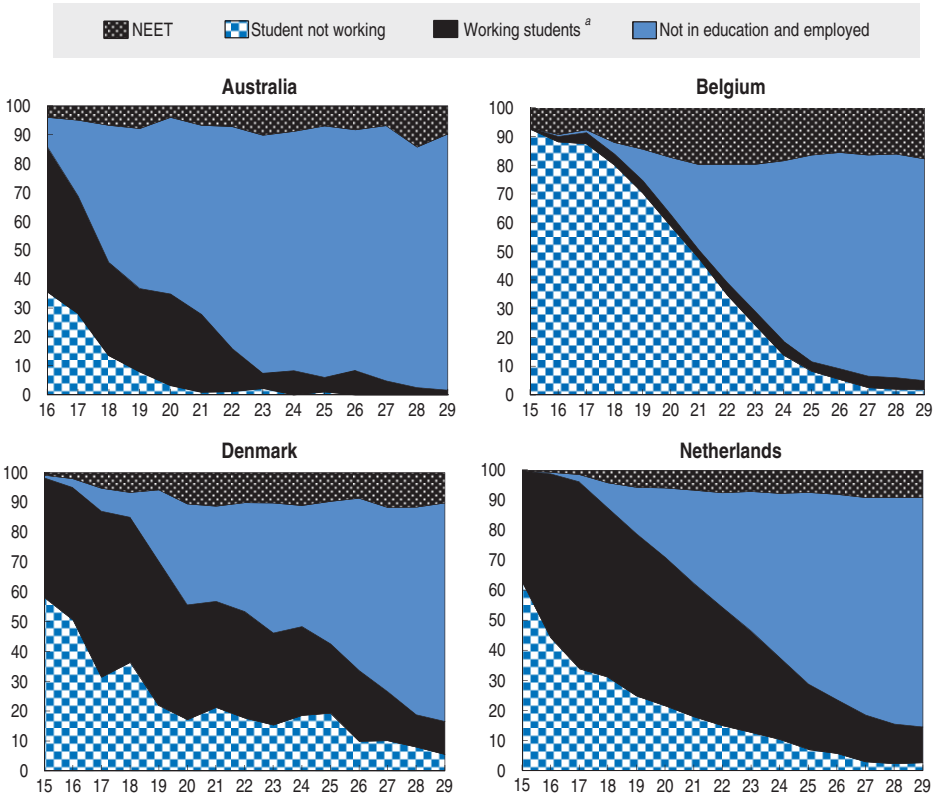
A difficult transition from school to work

The transition from school to work is difficult for many Belgian youth, in particular for youth with mental health problems. In 2011, the youth unemployment rate was 18.7% in Belgium compared with an OECD average of 16.2% and an unemployment rate of 6.4% for the age group 25-54 in Belgium (OECD, 2012c). There is a striking contrast between the three regions, though. The labour market is more favourable in Flanders, where youth unemployment was 16% in 2010, while in Wallonia and the Brussels-Capital Region, the youth unemployment rate was 30% and 40%, respectively, in the same year. Youth with a mental disorder are more likely to be unemployed and less likely to be employed than youth without mental disorders (OECD, 2012a); illustrating the additional challenges these young adults face to participate successfully in the labour market. The gaps in employment and unemployment rates were 13 and 18 percentage points, respectively, in 2008.[9]

A major factor in the difficult school-to-employment transition is the lack of relevant work experience among school-leavers (OECD, 2007b; VDAB, 2011). It is not common among Belgian youth to combine work and study, even though some of the technical and vocational education programmes offer an integrated school-work path. Yet, the quality of workplace training varies greatly across the different programmes (OECD, 2010c). Overall, only 10% of the 18-24-years old in education were employed in Belgium in 2009 (Figure 2.2) compared with an OECD average of 33% (OECD, 2011).

Figure 2.2. **Study first then work: the school-to-work transition in Belgium**

Study and activity status by single year of age: full-time students, working students, employed, and not employed and not in education (NEET); selected countries, 2009



a. Including apprenticeship and other work-study programmes.

Source: OECD calculations based on the European Labour Force Survey 2009 for Belgium and Denmark and Household, Income and Labour Dynamics in Australia Survey 2006 for Australia.

Youth unemployment receives a lot of attention from policy makers in Belgium and the regional public employment services (PES) receive additional resources from the federal level for active labour market programmes targeted at youth.[10] To tackle the lack of work experience, youth employment policy in Belgium is strongly targeted at a first job experience (*e.g. Premier Emploi* or S*tartbanen* at the federal level and *Individuele Beroepsopleiding in de Onderneming,* IBO, in Flanders). The PES also strengthened their outreach programmes and it is now very common for young people to sign up with the PES as a job seeker immediately on obtaining one's school-leaving diploma – in 2009, 84% of all school leavers in Flanders did so.[11] There is an incentive for youth in Belgium to enrol with the PES because it gives them entitlement to participate in active labour market programmes and an activation allowance (*allocation d'insertion* or *inschakelingsuitkering*).[12]

Career guidance towards the end of secondary education by the CLB centres could also be improved.[13] About half of the schools and CLB caseworkers that participated in a recent study by Vermaut *et al.* (2009) agreed that the information about the school-to-work connection is lacking or very restricted. CLB caseworkers are not always equipped to provide such advice, while schools do not see career guidance as a key role for the CLB centres. Career information sources beyond compulsory education are fragmented (OECD, 2010c).

Conclusion and recommendations

Without appropriate support, behavioural problems and mental ill-health affect the performance of children and youth at school and potentially their social and professional life as adults. The Belgian education system has comprehensive services in the school environment to give psychosocial advice to students and their parents and to support students at risk of dropping out. However, financial resources for specialised support remain concentrated in the special education system, while very little specialised support (in particular for students with behavioural and emotional disorders) is available in the mainstream school system. Also, despite the array of services to prevent school drop-out, the share of unqualified school leavers in Belgium is still high and close to the OECD average.

Youth with mental disorders are more likely than their counterparts to leave the education system without a degree and to face additional difficulties in entering the labour market (due to, for instance, low self-esteem, reduced social skills and other accumulated social risk factors). A pro-active approach of the public employment centres is thus particularly relevant for this group to ensure a successful transition from school to work.

The OECD report, *"Off to a Good Start? Jobs For Youth"* (OECD, 2010b) – see also the country report on Belgium (OECD, 2007b) – gives detailed policy recommendations in this area. For instance, to facilitate the transition from school to work in Belgium, dual apprenticeship systems should be extended to all skill levels (including high-skilled occupations as is being done in many OECD countries) and possibilities for paid or unpaid internships should be further developed in co-operation with employers. Unemployed youth, and in particular those with behavioural and mental health problems who often accumulate labour market disadvantages, should be assisted in their job search with appropriate measures, such as close mentoring, intensive job-search assistance and on-the-job coaching, ideally in co-operation with health and welfare services.

Recommendations

- Keep students with special needs in the mainstream school system to promote their social integration and develop support measures targeted at their needs, in particular for students with behavioural problems and mental ill-health.
- Give the CLB and PMS centres the authority and corresponding resources to co-ordinate all efforts and external services available to support schools and pupils in extra-curriculum tasks (such as the prevention of mental health problems, psychological support, specialised support for students with additional needs, school drop-out prevention, etc.). Ensure that the centres can work fully independent from schools.
- The platform *Integral Youth Help* which intends to improve the co-ordination between and co-operation among the different providers of youth services could be highly relevant for youth with mental health problems who often accumulate several social disadvantages. The development of the platform should be a high priority.
- The PES should devote more attention to behavioural and emotional problems among school leavers and unemployed youth. The CLB and PMS centres should closely co-operate with the PES when youth with mental health problems are leaving the education system and entering the labour market. If necessary, the health and welfare systems should also be involved.

Notes

1. Statistics were provided by the Flemish Department of Education.

2. In 2000, the CLB centres were merged with the Centres for Medical Surveillance at Schools (*Medisch Schooltoezicht* – MSTs) as their tasks had become more and more overlapping. For a short description of the history of both centres, see *www.ond.vlaanderen.be/clb/clb-medewerker/Achtergrond.htm* (in Dutch).

3. Statistics on the proportion of the caseload concerning mental-health issues are not collected.

4. The average waiting time for a first appointment with a Flemish centre for mental health is 54 days for children and youth, three weeks longer than for other age groups. One out of four children has to wait more than two months for a first appointment. The average waiting time for a second appointment is another 47 days on average. Data are obtained from the Flemish Agency for Care and Health (*www.zorg-en-gezondheid.be/*).

5. In Flanders, the Flemish Region transferred all its constitutional competences to the Flemish Community immediately after its establishment in 1980, which facilitated co-operation between departments responsible for community and regional matters.

6. Statistics on the CLB budget were provided by the Flemish Department of Education and statistics on the PMS budget were obtained from the Statistical Service Etnic (*www.statistiques.cfwb.be/*).

7. See, for instance, the recent Action Plan of March 2012 of the Flemish Department of Educational Development (*www.ond.vlaanderen.be/leerplicht/Documenten/actieplan-spijbelen-en-andere-vormen-van-grensoverschrijdend-gedrag-2012.pdf*).

8. *www.jeugdhulpwijzer.be/*.

9. Employment and unemployment rates of youth with and without mental disorders are estimated using data from the Belgian Health Interview Survey.

10. For an overview of all measures with subsidies and financial advantages for job seekers (including youth) and employers, see *www.autravail.be* (in French) or *http://www.aandeslag.be/* (in Dutch).

11. Statistics are obtained from the website of the Flemish public employment service (*http://vdab.be/*).

12. The activation allowance is awarded for a maximum period of 36 months (although some extension is possible) following a waiting period of 310 days. The benefit level depends on the family situation and the age of the job seeker (the upper age limit is 30 years), ranging in 2012 from EUR 256 per month for

a cohabiting person aged less than 18 to EUR 1 063 per month for a person aged between 18 and 30 with dependents (*www.rva.be*).

13. There have been recent initiatives by the CLB centres and the Flemish public employment services to develop a career guidance system based on labour market needs, but this has not resulted in concrete actions so far.

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Chapter 3

Employers and the working environment in Belgium

This chapter looks at the role of employers who are ideally placed to help people in the workforce to deal with mental health problems and retain their jobs. It first describes the link between working conditions and mental ill-health, reduced productivity and sick leave; then discusses prevention strategies to address the challenges in the psychosocial work environment; and, finally, looks at employer responsibilities and the involvement of occupational health services in this process.

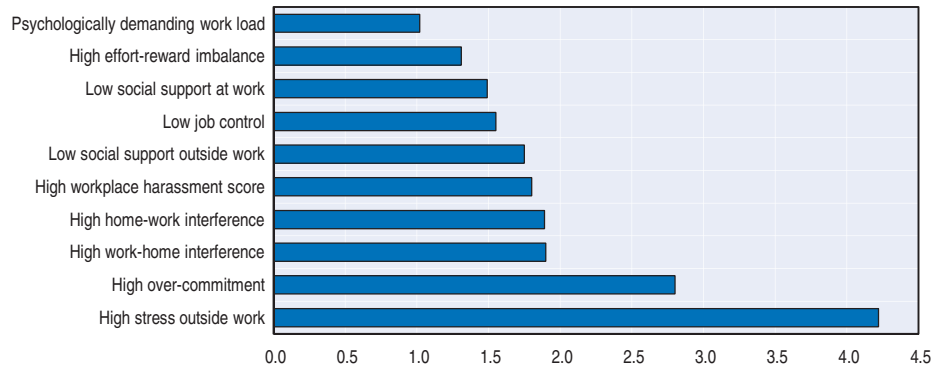
Employment rates of people with mental disorders are higher than is generally thought and there is increasing evidence that employment has positive effects on people's mental health by providing a social status, income security, a time structure and a sense of identity and achievement. Yet, poor quality jobs or a psychologically unhealthy work climate can erode mental health, and in turn influence the position of individuals in the labour market. Therefore, the working environment is a key target for improving and sustaining labour market inclusion of those with mental illness.

The relation between working conditions and mental ill-health

Epidemiological data for Belgium – Belstress III[1] – illustrate that people with low job control, high work-home interference, high effort-reward imbalance or over-commitment (*e.g.* taking work home) are 1.5-2.5 times more likely to have a depression, independent of their age, gender, education level and other psychosocial factors at or outside work (Figure 3.1).[2] Depression is, nevertheless, most strongly related with high levels of stress in private life.

Figure 3.1. **Relationship between work-related and private factors and depression**

Odds ratios from logistic regressions



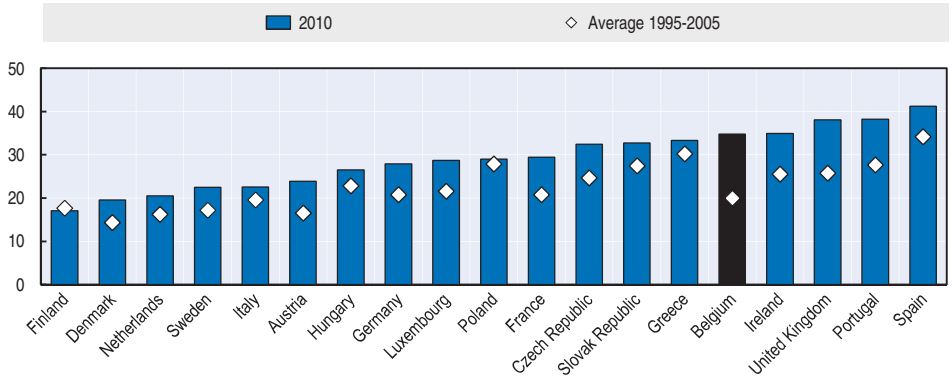
Note: The odds ratios represent the likelihood of a depression when people are confronted with certain work-related and private factors. A value equal to one indicates that there is no link between depression and the work-related or private factor; a value greater than one indicates a positive association; and a value smaller than one indicates a negative association. Associations are controlled for age, gender, education level and all other factors in the chart.

Source: Based on Kittel, F., I. Godin, E. Roy, C. Arnould, G. De Backer, E. Clays, C. Ghysbrecht (2007), "Belstress III Rapport de Recherche: Recherche des Déterminants de l'Absentéisme pour Cause de Maladies chez les Hommes et chez les Femmes", Université Libre de Belgique and Universiteit Gent, with corrections provided by Annalisa Casini, Els Clays and France Kittel.

As discussed in the recently published OECD report *Sick on the Job?*, working conditions relevant for a worker's mental health have worsened over time – not to be confused with the prevalence of mental disorders, which has remained stable. Not only has job insecurity increased, there has also been a tendency for job strain – *i.e.* a high degree of psychological demands and low decision latitude, a combination that enlarges the risk for common mental disorders – to increase over time. The rise in job strain over the past decade has been particularly large in Belgium (Figure 3.2).

Figure 3.2. **Job strain has increased considerably in Belgium over the past decade**

Proportion of workers with a high degree of psychological demands and low decision latitude in the workplace

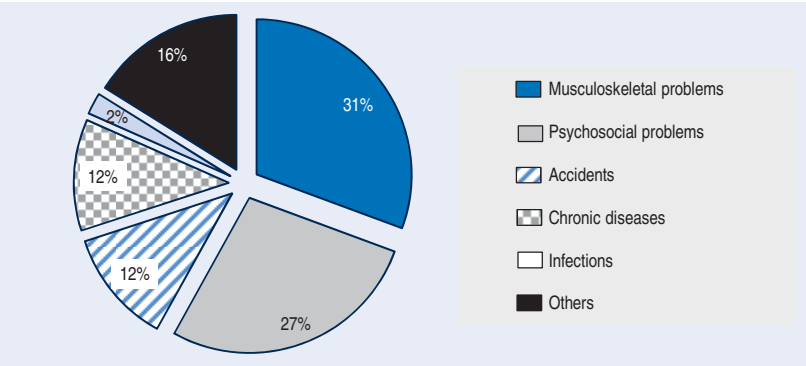


Source: OECD calculations based on European Working Conditions Survey (EWCS) 1990-2010.

Mental ill-health is an important determinant for sick leave

Most often, problems only become visible when employees are on repeated and/or extended work absences. Belgian survey data for private employees suggest that about half of the private sector employees had at least one day of sick leave during 2010 – 24% of the absences lasted for more than 5 days – and the average length of absence was 12 days (Securex, 2011).[3] The sickness absence rate among federal public employees was 70% in 2009, considerably higher than in the private sector, with 2.8% of the absences lasting for more than 30 days (Medex, 2010).[4] According to epidemiological data on sickness absenteeism in Belgium covering both private and public employees, mental health problems are the second most important determinant for long-term sick leave, after musculoskeletal problems (Figure 3.3).

Figure 3.3. **Causes of sickness absences of 15 days or longer among employees in Belgium, 2004-06**

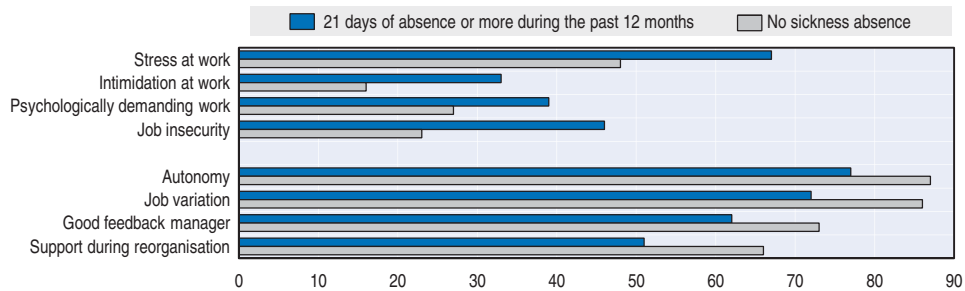


Source: Kittel, F., I. Godin, E. Roy, C. Arnould, G. De Backer, E. Clays, C. Ghysbrecht (2007), "Belstress III Rapport de Recherche: Recherche des Déterminants de l'Absentéisme pour Cause de Maladies chez les Hommes et chez les Femmes", Université Libre de Belgique and Universiteit Gent.

Stress at work is associated with higher and longer sickness absence among Belgian employees. According to Securex (2010), 67% of the employees with 21 days of sickness absence or more during the past year reported experiencing stress at work often to very often, compared with only 48% of the employees without sickness absence.[5] Employees on long or regular sick leave also report more often psychologically demanding work than employees without any sickness absence in the past year, with the respective percentages being 39% and 27%. Other working condition and organisational factors are also associated with variations in the duration and frequency of sickness absence, such as job variation and autonomy, intimidation at work, job insecurity, and support during reorganisation (Figure 3.4).

Figure 3.4. **The relationship between working conditions and sickness absence**

Percentage of workers agreeing with the following working conditions, by sickness absence duration



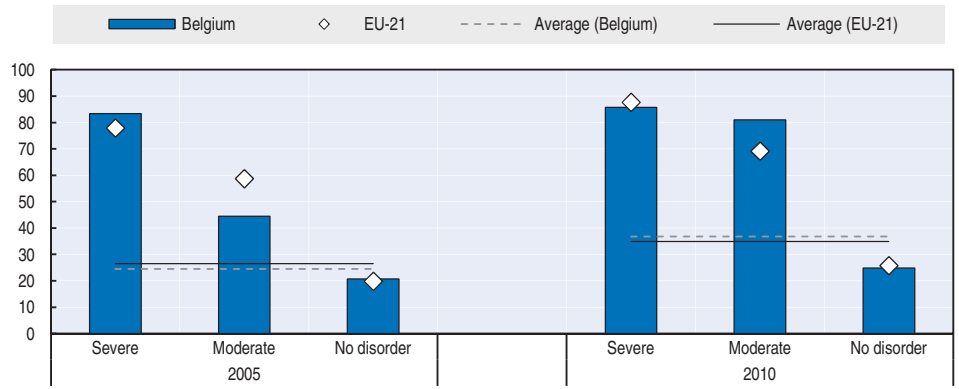
Source: Securex (2010), "Agir Face à l'Absentéisme", Whitepaper November 2010, Brussels.

Productivity losses through mental ill-health are large

Many workers with mental health problems do not take sick leave but instead may be underperforming in their jobs. European data suggest that many workers with mental disorders accomplish less at work than they would like to as a result of a health problem – a phenomenon called "presenteeism" (Figure 3.5). Presenteeism of this kind is very frequent not only among workers with severe mental disorders, but also among those with more moderate mental health problems where there has been a large increase in reported presenteeism between 2005 and 2010. Also Belgian survey data suggest that employees who had 21 days or more of sick leave in the past year are performing less than workers without sickness absence. The longer and the more frequent the sickness absence, the lower is the score on a variety of self-reported performance indicators: productivity, involvement at work and in the organisation, job satisfaction, willingness to change, and innovative and entrepreneurial spirit (Securex, 2010).

Figure 3.5. **Presenteeism has drastically increased among people with moderate mental disorders**

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



Source: OECD calculations based on Eurobarometer, 2005/06 and 2010.

Little understanding by management and co-workers (and often also by the individuals concerned themselves) of mental illness and the needs of workers with a mental disorder, implies that lower productivity levels of workers with mental health problems are often interpreted as a lack of motivation or competence, thus increasing the risk of dismissal. Yet, good

leadership and appropriate management have been recognised as some of the most critical factors in promoting a good working environment (Kelloway and Barling, 2010). As discussed in *Sick on the Job* (OECD, 2012), the role of the manager is even more critical for people with mental disorders as they are more likely to feel that they receive little respect and recognition at work.

The labour legislation gives explicit instructions

Belgium was one of the first countries to introduce the concept of well-being at work into the labour legislation (see Box 3.1). Employers are legally obliged to take all necessary preventative measures to protect the well-being of their employees. Contrary to most other countries, the Belgian legislation gives explicit instructions on how to deal with the mental health requirements mandated by law. In particular, all employers are required to do a risk assessment to identify situations and risk factors at the work place that can generate psychosocial distress caused by work, bearing in mind the content of the work, the employment and working conditions, and the labour relations. On the basis of such risk assessments, the employer must establish a five-year global prevention plan as well as an annual action plan to avoid psychosocial distress at work and limit its consequences. The risk analyses and prevention and action plans are typically realised in collaboration with a team of prevention advisors and employee representatives.

In addition, employers are obliged to appoint a psychosocial prevention advisor who assists the employer in the implementation of its psychosocial risks prevention policy. For companies with fewer than 50 employees, the psychosocial prevention advisor must be from an external prevention service (see Box 3.2) to avoid potential conflicts of interest.

It is strongly recommended (but not obligatory) to employers to appoint a confidential counsellor internally who is thoroughly familiar with the internal functioning of the company. The confidential counsellor supports employees with internal appeal procedures which each company should have in place for employees who are victims of violence or harassment. The employee can also file a complaint with the prevention advisor who can suggest specific measures, such as measures at the level of work organisation (*e.g.*, job description) or at the level of employment conditions (*e.g.*, the distribution of employees within the office space). In addition, the legislation foresees the possibility for employees to file a direct appeal to the Inspectorate for Well-being at Work or start a legal procedure.

Box 3.1. **Well-being at work**

In Belgium, reflections on psychosocial distress at work began in the 1990s, resulting in the Act on Well-Being at Work of August 4, 1996. The basic concept of health and safety at work was replaced by the broader concept of well-being at work, with the intent to cover all aspects of the work environment and promote a multidisciplinary approach to prevention. At the time, the concept of "psychosocial burden" was mainly associated with stress caused by work. A collective agreement of 1999, applicable to the private sector, required employers to take collective actions to prevent or remedy stress at work.

In 2002, a chapter on the protection of workers against violence and (sexual) harassment at work was introduced in the Act on Well-Being at Work. The law was complemented by a Royal Decree specifying the preventive and protective measures employers had to introduce against violence and harassment. As such, the law legitimised complaints and compensation claims and provided a framework for the prevention, detection, diagnosis and handling of workplace harassment phenomena and their effects at the level of the individual and the organisation. A new profession, professional advisor for the prevention of psychosocial aspects of work, was created and the duties of the confidential counsellor were expanded from sexual harassment at work to all kinds of violence and harassment at work. Besides, various risk-analysis tools were developed, including questionnaires to assess the organisational risks related to improper behaviour (*e.g.*, RATOG[1] and IDI[2)] and participative risk-management strategies (*e.g.*, SOBANE[3], *www.sobane.be*), and trainings and awareness campaigns (*e.g.*, *www.respectatwork.be*) were organised.

To address the prevention of psychosocial distress more generally, the Royal Decree of 2007 stipulated preventive and protective measures covering not only violence and harassment, but all aspects related to psychosocial burden, including stress (both from a collective and individual angle), conflict, physical or emotional abuse, etc.

1. RATOG (Dutch acronym for Risk-Analysis Tool for Undesirable Behaviour) analyses in a short and simple way (23 questions) the most important risk factors for undesirable behaviour (such as violence, bullying and sexual harassment) in a company. The questionnaire can be used in all sectors and a shorter version (18 questions) exists for small and medium-sized enterprises (RATOG-KMO) (Baillien *et al.*, 2006).
2. The Identification, Diagnosis and Intervention (IDI) tool for organisational risks of violence, bullying and sexual harassment at work consists of three steps: consultation, participation, and restitution. Consultation consists of a short questionnaire (20 questions) sent to 5-10 people within a company (*e.g.*, human resource manager, employee representative, confidential counsellor…) to detect the risk factors in the company. In the second step, the same group discusses the risk factors and suggests solutions, which are summarised in an action plan in the third step (Garcia *et al.*, 2007). The IDI-tool is freely available on *www.respectatwork.be.*
3. SOBANE is a step-wise participative strategy of risk prevention including four levels: Screening, Observation, Analysis, and Expertise. The first two levels build on the knowledge of the workers and try to solve problems internally following detailed guidelines described in the SOBANE strategy. Only when no solution can be found internally, do psychosocial prevention advisors (and other experts if necessary) analyse the situation and search for solutions together with the company (Malchaire *et al.*, 2010).

Box 3.2. **External services for prevention and protection at work in Belgium**

Each company is obliged to establish an internal service for prevention and protection at work. Within this service, one or more prevention advisors should be appointed to give advice on all matters related to the well-being of workers and to help all parties involved (employer, line managers and workers) with the application of the measures mentioned in the law on well-being at work. In companies with less than 20 employees, the employer is permitted to be the prevention advisor. When the internal service cannot perform all of the required tasks, the company must call in an external service for prevention and protection at work approved by the Federal Minister of Employment and Labour.

The external services for prevention and protection at work consist of two sections, each employing prevention advisors specialised in different fields:

- *Medical surveillance:* Occupational doctors are assisted by nursing and administrative staff. These occupational doctors advise employers on how to create a healthy work environment (primary prevention), perform regular (yearly, bi- or tri-annual, depending on the exposure to risk factors of employees) medical check-ups to identify potential health problems (secondary prevention), and assist employers in the reintegration of employees after long-term sickness absence.

- *Risk management:* Prevention advisors work in multidisciplinary teams to bring together different expertises. They are specialised in one or more of the following five fields: safety at work, occupational medicine, ergonomics, occupational hygiene, and psychosocial aspects of work. When performing a risk assessment, one single prevention advisor may not simultaneously represent more than two fields and the same team of prevention advisors is always responsible for an employer.

For companies with fewer than 50 employees, the psychosocial prevention advisor must be from an external prevention service. In addition, the psychosocial prevention advisor may never simultaneously hold the position of prevention advisor authorised for occupational medicine to avoid a potential conflict of roles.

Currently, there are 13 recognised external services for prevention and protection at work in Belgium, represented by the sector federation Co-Prev.[1] Together, these external services employ about 3 000 prevention advisors, of which 112 are psychosocial prevention advisors, and cover 205 000 companies (about one third of all enterprises) and 3 240 000 public and private sector employees (about 85% of all employees). The number of psychosocial prevention advisors working in internal prevention services (large companies tend to organise prevention tasks internally) is estimated at about 100-150.

1. For a list and contact details of the recognised external services for prevention and protection at work, see *www.werk.belgie.be/erkenningenDefault.aspx?id=5040*.

The practical implementation of the law remains deficient

A recent evaluation reveals that the value of the legislation is recognised by all stakeholders, but that the practical implementation of the legislation on well-being at work remains deficient (Service public fédéral Emploi, Travail et Concertation sociale, 2011). First, the psychosocial risk analyses are not very often carried out by employers, with the main obstacles being the high cost involved, in particular for SMEs who typically have to buy services from external prevention services, and the resistance of employers who fear a negative analysis and the implications this may have on the organisation of work. The administrative sanctions for non-compliance are actually cheaper than the risk analysis itself. Second, the evaluation also brought to light that the majority of employers are not aware about their legal obligations and the importance and advantages of prevention policies. Most often, employers do not know their psychosocial prevention advisor until they are contacted by the latter following a complaint by one of their workers. Many employers see this as an intrusion of their domain and obstruct co-operation with the prevention advisor. Yet, the co-operation of employers is crucial to effectively reduce the psychosocial burden at work. Third, from the side of the employees, there is a lack of awareness about the role and existence of the psychosocial prevention advisors and confidential counsellors. Finally, psychosocial prevention advisors have little to no time for the prevention of psychosocial risks at the work place as they are fully occupied with individual complaints of harassment at work. Given that less than 5% of the prevention advisors are specialised in psychosocial aspects at work (see Box 3.2) despite the likely scale of workers with mental ill-health, this finding is not surprising. In addition, psychosocial prevention advisors are not always trained to execute the wide range of possible risk assessments and prevention programmes, and they are seldom familiar with the workplace. Yet, the lack of financial incentives for employers to adapt the work and workplace tends to discourage occupational health specialists to act in this field and makes the co-operation with some companies difficult (Mortelmans, 2006).

Conclusion and recommendations

Belgium is one of the few countries with explicit instructions in the labour legislation on the prevention of mental health problems at work. The implementation of the law is far from optimal, however. Companies tend to be badly informed about their obligations and the majority of them do not undertake the legally required psychological risk analyses because of the high cost and the negative connotation attached to it. Yet, such risk analyses, combined with the compulsory five-year prevention plan and an annual

action plan, would help employers to limit mental health problems caused or aggravated by work and protect the well-being of their employees. The psychosocial prevention advisors and confidential counsellors are ideally placed to support employers with the prevention of mental health problems at work, in particular for SMEs who often do not have the resources and knowledge internally. Yet, the co-operation with the external psychosocial prevention advisors is not optimal, and sometimes very poor. Belgian policy makers acknowledge the need for improvement of the implementation of the legislation as reflected in the recommendations (some of which are proposed as well below) made by the Parliament in 2011 (Chambre des représentants de Belgique, 2011).

Recommendations

- The risk-assessment obligations in the labour law should be rigorously implemented and monitored and non-compliance sanctions should be higher than the costs of undertaking risk assessments. Companies should be given one year to fulfil their legal obligations and the monitoring authority should get sufficient resources to monitor compliance with the labour law.
- Awareness campaigns should be organised to provide employers with more and better information about their legal obligations as well as the available risk-assessment tools and prevention measures.
- Better implementation of the risk-assessment obligation would increase the employers' demand for support from their prevention services. To satisfy that demand, the number of psychosocial prevention advisors should increase significantly and they should be trained in advising employers on how to deal with workers with psychological problems to prevent sickness absence and job losses.
- Services for prevention and protection at work need to change their focus from traditional challenges (*i.e.* preventing work injuries and occupational accidents and diseases) to new challenges at the workplace (such as prevention of mental health problems, job retention and job reintegration after sickness absence).

Notes

1. Belstress III is epidemiological research about the determinants of sickness absenteeism with a special focus on gender aspects (Kittel *et al.*, 2007). Between 2004 and 2006, 2 983 employees, aged 30-55, from seven large companies or public administrations across Belgium participated in the study. The respondents cannot be considered representative in the Belgian workforce, however.
2. The same findings hold for anxiety disorders (results are not presented here).
3. Securex is one of the 13 external services for prevention and protection at work active in Belgium (see Box 3.2). Their research on absenteeism in the private sector is based on a representative sample of 254 305 employees and 25 480 employers, surveyed in 2010.
4. This statistic is not based on survey data, but on the sickness absence database of the federal public sector which has information on all sickness absences of at least one day.
5. These statistics are based on a representative sample of 1 540 Belgian employees in the private sector, surveyed at the beginning of 2010.

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Chapter 4

Belgium's sickness and disability benefit system

This chapter looks at the role and functioning of the Belgian sickness and disability insurance system. It pays particular attention to responsibilities and incentives of the key stakeholders, i.e. employers, occupational health services, general practitioners and mutualities, to tackle sickness absence early on and reintegrate sick workers as soon as possible. It also discusses reintegration measures the mutualities have at their disposal.

Frequent and prolonged sickness absences can easily become a main hindrance for beneficiaries to remain at work or return to the workplace. Systematic monitoring of sick-leave behaviour and early intervention in co-operation with the employer are thus needed to prevent labour market detachment and potentially long-term disability benefit dependence of people with mental disorders. The earlier support is given, the more likely it is that higher severity of mental illness and co-morbidity with somatic or other mental illness can be avoided – two factors making labour market reintegration particularly difficult.

There is no focus on sickness management or return to work

During the first month of sick leave (two weeks for blue-collar workers; see Box 4.1 for the difference between blue-collar and white-collar workers in Belgium), the employer is responsible for paying the sickness benefit (the so-called guaranteed wage period). Sick workers have to inform their employer and, if requested by the contract or collective agreement (this is the case for most workers), present a medical certificate within two days of absence. The employer can request a visit by a control doctor, who verifies whether the employee is able to perform their job and the length of sickness leave proposed by the general practitioner. The reason for sickness absence, as well as other medical information, is confidential and cannot be shared with the employer.

If sick leave lasts for more than one month (two weeks for blue-collar workers), the mutual insurance provider (mutuality – see Chapter 1 for more information on the institutional set-up) and prevention advisor-occupational doctor have to be informed. From then onwards, the mutuality is responsible for paying the sickness benefit of the insured.[1] The employee has to send a medical certificate, specifying the starting date and reason for sick leave (filled in by their general practitioner) to the mutuality before the end of the guaranteed wage period (sickness benefits are reduced by 10% during the period of delay). Employers from their side are required to inform the occupational doctor.

In the following sections, the role in sickness management of each of the key stakeholders is discussed. In particular, employers and their occupational doctors, general practitioners and control doctors, the mutualities and their insurance doctors, are all critically positioned to support an employee in recovering and returning back to their job.

Box 4.1. **Blue-collar versus white-collar workers in Belgium**

Employees in the private sector are divided into two main categories in Belgium: blue-collar workers (42% of all employees in the private sector in 2011)[1] and white-collar workers (58% of all private-sector employees).

The distinctions between both groups are reflected in the individual labour law as well as in all major structures of the labour system. For instance, blue-collar workers have shorter notice periods than white-collar workers and thus receive less compensation in the event of dismissal.[2] Other differences in the reciprocal rights and obligations of the employer and the employee are the length of the initial trial period and the frequency of wage payments. In addition, there are separate unions for blue-collar and white-collar workers, different joint committees, separate election lists for the works council and workplace health and safety committee, and different chambers of the labour courts.

Belgium is one of the few countries in the OECD where employees are still divided into blue-collar and white-collar workers. Luxembourg harmonised the rules for both categories in 2008 and Austria introduced the *Abfertigung Neu* system – a new unified framework for severance payments – in 2003. Although the social partners in Belgium agree that the distinction is outdated and negotiations have been ongoing for several years, they are not yet able, for political and financial reasons, to agree on the creation of a unified status for workers. Cases of disputed classification between blue-collar and white-collar workers are referred to the labour courts, through which the distinction is now being challenged as incompatible with the principle of equality before the law enshrined in the Constitution.

1. *Source*: Directorate-general Statistics and Economic information (*http://statbel.fgov.be/*).
2. Severance payments in the strict sense do not exist in the Belgian labour law legislation. Yet, in case of dismissal without notice, the employee receives a payment equal to the applicable notice period.

Employers do not play an active role in early intervention

Employers do not generally play an active role in the job-retention and integration of people with mental health problems as the financial incentives to do so are limited. During the guaranteed wage period, employers are the only ones (besides the general practitioner) who know about the employee's absence and are thus ideally placed to monitor absences. Yet, with the employers' financial responsibility for sickness benefits limited to one month/two weeks, it is difficult to motivate them to provide back-to-work support for workers after that period, especially since many employers perceive the costs of new recruitment and training to be lower than the costs of retention, adjustment and accommodation of workers with (mental) health problems (OECD, 2010). Although the employer has to inform their prevention advisor-occupational doctor about each employee absent for more than four weeks, this rarely happens in practice as they are no longer financially involved. Even if they inform the occupational doctor, the latter

has little or no time to intervene as they spend most of their time on regular medical check-ups.

The law on well-being at work foresees an active role for the company's occupational doctor to support the employee in recovering or learning to manage their condition such that they remain in work. Besides advising employers on creating a work-health environment (primary prevention) and performing regular medical check-ups to identify potential health problems (secondary prevention), the prevention advisor-occupational doctor can, since 2003, also assist in the reintegration of employees after a long-term sick leave. In particular, after a sick absence of at least four weeks, employees can request a medical examination by the occupational doctor and discuss the support they may need to take up work again. This visit would also allow the occupational doctor to request adaptation of the job or work environment by the employer. Yet, very few employees are aware of this possibility and mainly associate the occupational doctor with the regular medical check-ups (Service public fédéral Emploi, Travail et Concertation sociale, 2009). Occupational doctors, on the other hand, are legally not allowed to contact employees during their sickness absence.

The psychosocial prevention advisor (and internal confidential counsellor) could be particularly useful for the reintegration of people with mental health problems as they are specialised in psychosocial aspects and workplace matters. Yet, the reintegration visit is always carried out by the occupational doctor and the latter has little to no contact with the psychosocial prevention advisor despite the fact that they belong to the same external prevention service for prevention and protection at work. Instead, the occupational doctor is more likely to contact the employee's general practitioner or treating psychiatrist to obtain information about the employee's medical condition.

Illness is a justifiable reason for contract termination in Belgium and employers can be exempted from their notice-period obligations if the worker is declared to be permanently unable to perform the job by the occupational doctor (so-called medical *force majeure*).[2] The employer is obliged, however, to do everything possible to adapt the work (environment) or to offer a different job in line with the capabilities of the employee. Only when the reintegration attempt fails (because it is not technically or objectively feasible, too expensive, or because the employee refuses) and the permanent disability is confirmed by the social inspection doctor of the Federal Public Service for Employment, Labour and Social Dialogue, can the employer dismiss the worker because of medical *force majeure*.

The medical visit with the occupational doctor thus has an ambiguous role. On the one hand, an employee can contact the occupational doctor to

discuss reintegration options after a long-term sick leave. On the other hand, the occupational doctor can declare a worker disabled and thus give the employer the possibility to dismiss the worker without further obligations. Hence, it is not surprising that very few sick employees contact their occupational doctor voluntarily to discuss back-to-work measures as they fear losing their job.[3]

In some cases, the medical *force majeure* option is used by the employee to get access to unemployment benefits. If employees on sick leave feel they may lose their entitlement to sickness benefits because of an improvement in their medical condition, but do not want to return to the same employer, they try to come to an agreement with the employer to be dismissed for medical reasons. This option exempts the employer from their notice-period obligations and gives employees access to unemployment benefits, which they would not receive in case of a voluntary separation. Although the legislation regarding the medical *force majeure* has been strengthened in 2007 to limit such social fraud, external prevention services continue to complain about being put under undue pressure to declare an employee disabled. Indeed, anecdotal evidence suggests that the medical visit with the occupational doctor results in a declaration that the worker is disabled in nearly all the cases, rather than in a plan to integrate the employee back in employment.

General practitioners are not involved in the reintegration process

Like employers, General Practitioners (GPs) are key players in sickness monitoring and management. The decision they make about a person's health status determines how long that person can remain detached from their workplace and claim sickness benefits. This is crucial because allowing employees to stay out of work for an extended period of time greatly diminishes their chances for a successful return to work.

As has been observed in many countries, there is considerable variability in the decisions GPs make about sick leave, particularly in the duration granted. In most countries client demand (for more rather than less leave) is the only overt incentive in play (OECD, 2010). Several countries (*e.g.* Ireland, the Netherlands, and Sweden) have introduced medical guidelines on the "ideal duration" of sick leave – based on scientific evidence and developed and agreed among doctors – to encourage earlier return from sick leave (OECD, 2010). No such guidelines exist in Belgium, even though the scientific societies of occupational physicians and insurance doctors have been calling for their introduction (SSST-ASMA, 2010, and Service public fédéral Emploi, Travail et Concertation sociale, 2009). Control doctors in Belgium – hired by companies, but different from occupational doctors[4] – can to some extent limit abuse and the granting of

inappropriately long sick leave, but, as there are no objective tests for most mental health problems, it is very difficult to detect potential abuse. Moreover, these controls of absence in Belgium are targeted towards frequent short-term absences as these are assumed to be more damaging to the functioning of a company than long-term absences (Securex, 2011). Thus, they have little impact on shortening inappropriately long sick leave.

In addition, GPs are currently hardly involved in the reintegration of sick employees (VBO, 2011). Yet they know best the employee's medical and socio-familial situation and their support may often be a crucial and necessary condition to motivate the employee towards work resumption (Mortelmans *et al.*, 2006). Unfortunately, there is very little communication between GPs, mutuality doctors and occupational doctors, and GPs are seldom involved in the decision to grant or suspend sickness and disability benefit entitlement (Service public fédéral Emploi, Travail et Concertation sociale, 2009).

Mutualities are too passive in managing sickness absences

While the mutualities could play an active gatekeeper role in the access to sickness benefits, they are quite passive with no strong focus on sickness management or return to work, even though the professional integration of sick workers is part of their responsibilities and several activation tools have been put in place (see Box 4.2). In addition, the mutualities have no financial incentives to encourage a quick return to work as the budget they receive from the National Institute for Sickness and Invalidity Insurance is mostly based on the *number* of members, with only a very small part based on their results.

Sickness status is assessed by the insured's general practitioner, but has to be confirmed (or rejected) by the mutuality doctor within five days after reception of the GP's medical certificate (which has to be sent to the mutuality before the end of the guaranteed wage period, see above). The mutuality doctor has to invite the insured for a medical visit, but the decision when to invite the person for medical assessment is entirely up to the mutuality doctor with the only condition that each person reaching one year of sick leave has to be checked at least once. In many cases, much crucial time goes by without any effort to shorten the sickness absence period. This is unfortunate, especially since the Belgian sickness and disability benefit system is far more integrated than in other countries and would easily allow for early intervention. Unlike in most OECD countries, the National Institute for Sickness and Invalidity Insurance in Belgium is financially responsible for both sickness and disability benefits and applies the same eligibility criteria for both benefits. Hence, the Fund could reap the benefits of early activation itself.

Box 4.2. **Activation measures of the National Institute for Sickness and Invalidity Insurance (RIZIV/INAMI)**

Part-time work

Since 1996, sickness and disability beneficiaries are allowed to work on a part-time basis and can accumulate sickness benefits and wages, if three conditions are fulfilled: their work disability remains at least 50%; the job does not jeopardise their health; and they have the permission of their mutuality doctor beforehand. The latter also decides about the intensity and duration of part-time work, but it can be unlimited in time. Part-time work is not necessarily 50%, but can be less or more, as long as the disability remains at least 50% in medical terms. If an improvement in the health situation is envisaged, the hours and days worked may be gradually increased over time until the beneficiary is ready for regular or full duty.

Benefits are automatically adjusted according to the wage earned on the job. Calculations by Bogaerts *et al.* (2009), which take into account the person's household situation as well as changes in other taxes and benefits as a result of employment, illustrate that part-time work at the minimum wage implies an increase in total net income in all cases, ranging from 1% (for a single person with children receiving the maximum sickness or disability benefit who starts working at 33%) to 63% (for a person in a couple-family without children receiving the minimum sickness or disability benefit who starts working at 50%). Moving from the minimum sickness or disability benefit into full-time work at the minimum wage also implies an increase in income for all people irrespective of their household situation (ranging from 12% without benefit to 82% if the person can keep part of his or her benefit, as is the case, for instance, in sheltered employment). Only when a person moves from the maximum sickness or disability benefit into full-time work at the minimum wage will he or she experience a decrease in income (ranging from minus 2% to minus 18%) irrespective of their household situation (with the only exception being a person living in a dual-earner couple without children).

Voluntary work

Sickness and disability beneficiaries are allowed to engage in voluntary work without losing their benefits entitlements, but the same conditions which apply for part-time work have to be fulfilled. Voluntary work is not considered as work as such and can also be done on a full-time basis.

Vocational rehabilitation

Sickness and disability beneficiaries can follow a training or rehabilitation programme, but participation is not obligatory and the programme has to be approved by the National Institute for Sickness and Invalidity Insurance. Since July 2009, the costs of the training (inscription, materials, public transport, *etc*.) are covered by the latter, without limitation on the length of the programme or the cost (as long as it has been approved). Participants continue to receive their benefits and are paid 1 euro for each hour of training plus a lump-sum payment of EUR 250 at the end of the training. After the training programme, participants have only six months to find a job before they lose their sickness benefit entitlements.

The Belgian sickness and disability scheme uses a medical-economic definition for sickness/disability: to be eligible for benefits, a worker has to suffer from a loss of earnings capacity of 66% or more as a result of injuries or functional difficulties, or aggravation of these. Any job a person did, or could possible do according to his/her qualification and experience, is considered. However, if the illness shows a favourable evolution, only the usual occupation is taken into account during the first six months to determine the earnings capacity loss.

Since 2006, professional integration of sick workers is the legal responsibility of the mutuality doctors, but the approach remains very medically oriented with no attention to the employment side (Service public fédéral Emploi, Travail et Concertation sociale, 2009). Reintegration programmes are typically presented by the mutuality doctor during the medical control and only followed up by social workers if the insured is interested in a particular programme. In particular, the medical visit with the mutuality doctor (called control visit, see, for instance, the information brochure of Mutualité Libre Securex, 2010, one of the Belgian mutualities) is often formal and short, and used more to "create a file" rather than to assist people in their return to work (Service public fédéral Emploi, Travail et Concertation sociale, 2009). Besides, the mutuality doctor has little or no information about the work environment of the insured and there is no communication between them and the occupational doctor, or with the public employment centres. Finally, the decision on vocational rehabilitation is taken solely by doctors, without involvement of employment specialists.

The existing (re-)integration measures are not necessarily suitable for people with mental health problems. First, vocational rehabilitation for people with physical disabilities is more straightforward – a person who lost his or her arm and can no longer exercise his or her function should be retrained for a different occupation. For people with mental health problems, vocational rehabilitation should be interpreted in a much broader way, for instance, on-the-job coaching and support may be most appropriate for many of them. Despite this, no such services are offered by the National Institute for Sickness and Invalidity Insurance and co-operation with the public employment centres has started only very recently and so far the take-up of active labour market programmes by sickness and disability beneficiaries is very low (see Chapter 6). Second, participants lose their entitlement to disability benefits within 6 months after the end of the vocational training. The reasoning behind this rule is that vocational rehabilitation restores the work capacity of the participants; the person is thus supposed to enter the labour market again. Yet, they hardly receive any support in their job search (there is only one job coach attached to each centre); many will therefore shy away from following vocational

rehabilitation. Third, while it is legally possible to gradually increase working hours, this is very difficult for the employer from an administrative point of view as a change in working hours implies a change in contract. Yet, for people with mental health problems, progressive employment would be a good opportunity to get used to the work rhythm again and lose their fear of not fulfilling work requirements. Fourth, people with a small recurrence of their (mental) health problem who would temporarily need part-time work (combined with partial benefits) are obliged to first go on full benefits and then apply for part-time work.

As a result, the activation measures are hardly used even though the majority of people on long-term sick leave wish to work and would need support to do so. Statistics provided by the National Institute for Sickness and Invalidity Insurance for 2010 show that only 3.4% of the sickness beneficiaries made use of the possibility to work on a part-time basis and less than 0.2% of them were officially engaged in voluntary work (data on the underlying diagnosis for sickness absence are not collected). Data for the Flemish administration confirm these figures: only 5.8% of their employees who are on sickness benefits for less than one year are enrolled in the progressive return-to-work programme (Bestuurszaken, 2011).

A small survey undertaken among 100 persons on long-term sick leave (between three and six months) in the province of Liege in 2011 revealed that the majority of them expressed a wish for an adaptation of their job to make a quick return to work possible (Service public fédéral Emploi, Travail et Concertation sociale, 2009). In particular, they would need a less demanding function, shorter working hours and/or support from colleagues. According to the survey, apart from a lack of improvement of their health condition, the biggest obstacles to return to work are, a lack of understanding from their colleagues, time-consuming treatments, a fear of not performing well upon their return to work and not being able to test their work capacities before they return to work (which is typically on a full-time basis from the start). A Flemish survey from 2001-03 with a sample of 1 900 persons on long-term sick leave confirms their willingness (and possibility) to work: eight out of ten persons in the sample were willing to consider partial work while recovering from their health problem (Service public fédéral Emploi, Travail et Concertation sociale, 2009). Although these surveys do not distinguish the underlying diagnosis for sickness absence, the results are likely to be particularly valid for people with mental health problems.

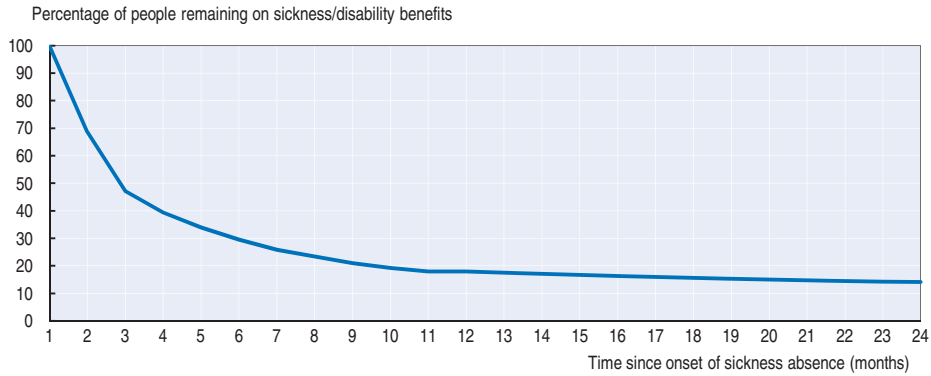
Smooth transition from sickness to disability benefits

Before the end of the first year of sickness absence, the mutuality doctor sends a recommendation on the beneficiary's work-ability status to the

medical board of the National Institute for Sickness and Invalidity Insurance. Based on this document, the board decides to accept or reject a disability benefit claim, while a new medical assessment is only required if the board disagrees with the mutuality doctor. Overall, the eligibility assessment is based mainly on medical grounds and only on the opinion of doctors, without involvement of the employer, caseworkers or employment specialists.

In practice, nearly all disability claims are accepted. In 2010, 44 000 people – or about 18% of the total number of sickness beneficiaries with an absence of at least one month – entered the disability benefit system.[5] About one third of them suffered from a mental disorder as the primary condition. Unfortunately, information on the number of rejections is not collected, but data on the duration of benefits recipiency show no break in the exit rate from sickness benefit to work around 12 months, the moment of transition from sickness benefits onto disability benefits (Figure 4.1).

Figure 4.1. **Return to work becomes difficult after three months of sickness absence, 2010**



Note: The National Institute for Sickness and Invalidity Insurance has only information on the sickness absences for which the mutualities pay sickness benefits, *i.e.* after the guaranteed wage period. To provide a consistent picture across blue-collar and white-collar people, the vertical axis shows the number of people receiving sickness or disability benefits as a percentage of the number of people receiving sickness benefits for at least one month. However, the time since onset of sickness absence (horizontal axis) includes the guaranteed wage period. The outflow curve is constructed on the basis of the duration of sickness benefits (first twelve months) and disability benefit outflows (from the thirteenth month onwards) for 2010.

Source: OECD calculations based on data from the National Institute for Sickness and Invalidity Insurance.

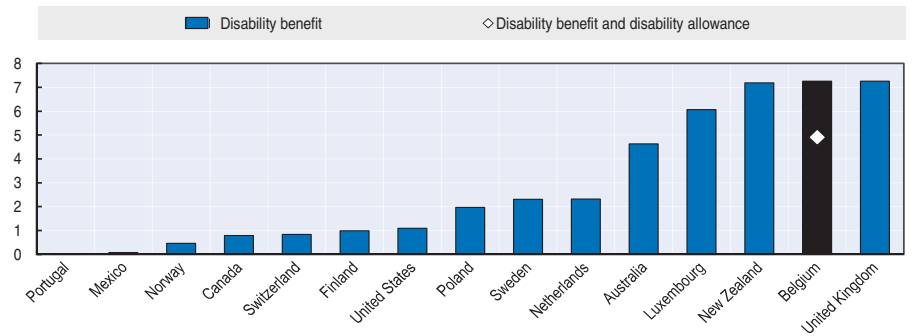
About 2.5% of the sickness beneficiaries reaching 12 months of absence leave the system at that moment. This is not necessarily due to a benefit rejection, but could also be the result of an improvement in their health condition and a return to work.

Outflows from disability are frequent

Nevertheless, outflow rates from disability benefits are high in Belgium compared with other OECD countries. In 2008, 7.3% of the total number of disability beneficiaries moved into employment or lost their benefit entitlement. In most other OECD countries for which data are available, the outflow rate was around 1-2% in that period, except for a few countries (Figure 4.2).[6] The share of people finding a job is especially high in Belgium – accounting for about half of outflows for reasons other than death or retirement, compared with only 20% and 35% in New Zealand and Sweden respectively, the only two countries for which such information is available. This result is rather surprising given the rather passive approach of the National Institute for Sickness and Invalidity Insurance and the mutualities. If outflows from the disability allowance system (see next section) are also taken into account, the outflow rate for Belgium drops to 4.9%, but still remains higher in than most other OECD countries.

Figure 4.2. **Outflow from disability benefits is relatively high in Belgium**

Annual outflows from disability benefits as a share of all disability benefit recipients (percentage), latest available year[a,b]



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

b. Data refer to: 2004 for Luxembourg; 2005 for Australia and the United Kingdom; 2006 for Finland; 2007 for Canada, Poland, Portugal and the United States; and 2008 for Belgium, the Netherlands, New Zealand, Norway, Mexico, Sweden and Switzerland. Data for Canada and the United States refer to contributory pensions only; data for Poland to the contributory farmers' scheme; and data for the United Kingdom to the Long-Term Incapacity Benefit.

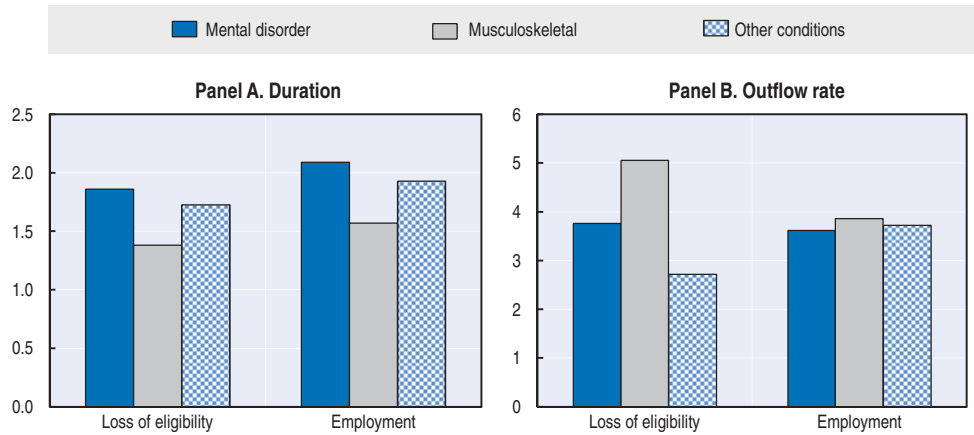
Source: Data provided by national authorities.

The high outflow rate from disability benefits is related to the fact that disability benefits in Belgium are not *permanent* in nature *per se*, contrary to the situation in most other countries. Even after a person has entered the disability benefit system, the mutuality doctor can request a regular control

visit – with the frequency depending on the type of disorder and the likelihood of recovery, but the decision is fully left to the mutuality doctor – during which the work-ability status of the beneficiary is re-evaluated. At any moment, the mutuality doctor can decide to stop the benefit entitlement, without having to ask permission from the medical board of the National Institute for Sickness and Invalidity Insurance. Data from the National Institute for Sickness and Invalidity Insurance show that, on average, people receive disability benefits for 1.6 years before losing entitlement (in addition to one year of sickness benefits), while the average length of benefit recipiency before moving into employment is nearly two years.

Figure 4.3. **People with mental disorders stay longer on disability benefits than people with musculoskeletal problems**

Average duration of disability benefit recipiency (in years) and outflow rate as a percentage of the total disability stock, by reason of outflow, 2010



Source: OECD calculations based on data from the National Institute for Sickness and Invalidity Insurance.

People with a mental disorder stay longer on disability benefits before losing their entitlement or moving into employment than people with muscular-skeletal conditions (Figure 4.3). The averages for both groups are, respectively, 1.9 and 1.4 years in case of benefit eligibility loss and, respectively, 2.1 and 1.6 years for employment (Figure 4.3, Panel A). People with a mental disorder also face lower rates of eligibility loss than people with muscular-skeletal conditions (respectively 3.8% and 5.1%), but higher rates than disability beneficiaries with other conditions (2.7%; Figure 4.3, Panel B). The outflow rate into employment is relatively similar across disabilities. Data for Australia, the Netherlands, and the United States point

to similar conclusions: disability beneficiaries with a mental disorder are under-represented among benefit terminations and the likelihood to leave the benefit because of recovery is also lower among this group than among beneficiaries with musculoskeletal conditions (OECD, 2012).

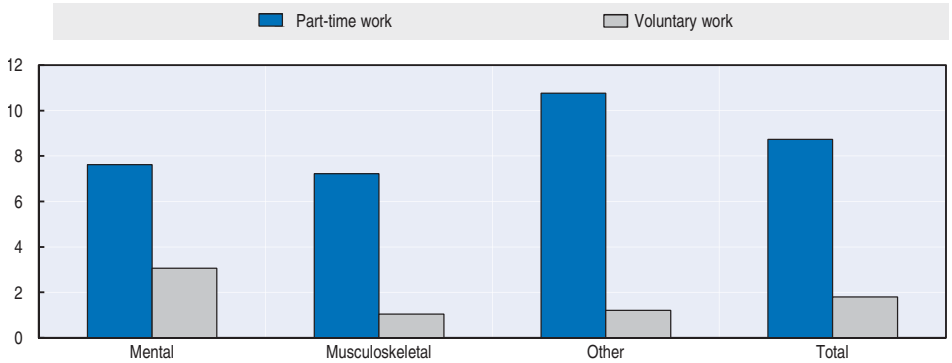
Activation measures are optional

Belgium does not have a partial disability benefit as in some other OECD countries, but beneficiaries are allowed to work and their benefit is adjusted according to the salary they earn. However, they need the permission to work from their mutuality doctor beforehand, be it paid or unpaid work (see Box 4.2 above). The main difference is that in Belgium, it is the beneficiary who chooses whether or not he or she wants to work, while in countries with partial benefits, the disability benefit authority decides on the degree of disability and grants partial benefits in line with people's remaining work capacity to encourage them to remain in work or to return to employment (OECD, 2010).[7]

Since work is optional in the Belgian sickness and disability benefit system, very few people receiving benefits are engaged in part-time or voluntary work. At the end of 2010, 8.7% of the disability beneficiaries had an active permission to work part-time, while barely 1.8% worked on a voluntary basis (Figure 4.4). People with mental health problems are slightly less likely to work on a part-time basis (7.6%) than people with other disabilities, while voluntary work is slightly more common among this group – though still very low at 3.1%. The number of disability benefit recipients participating in vocational rehabilitation is negligible (about 400 persons in 2010) and there are only two vocational rehabilitation centres in Belgium, one in Flanders and one in Wallonia. The lack of interest in vocational rehabilitation is partly related to the recent introduction of such programmes (see Box 4.2), but largely the result of the fact that participants lose their entitlement to disability benefits within 6 months after the training (as discussed above). Many beneficiaries will therefore shy away from following vocational rehabilitation.

Figure 4.4. **Very few people with mental health problems on disability benefits are engaged in activation measures, although slightly more so than people with musculoskeletal problems**

Number of work authorisations as a percentage of the number of beneficiaries at the end of 2010, by health condition



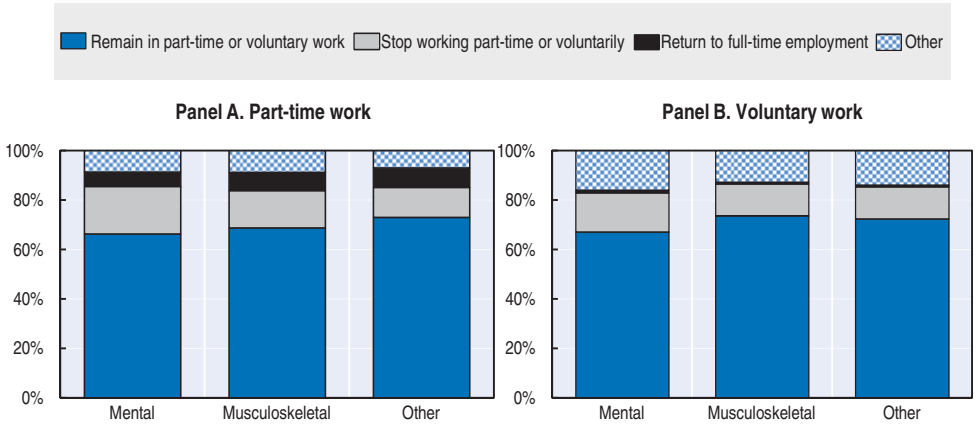
Source: OECD calculations based on data from the National Institute for Sickness and Invalidity Insurance.

Neither part-time work nor voluntary work is a stepping stone into full-time employment. Of those beneficiaries with a mental disorder who were authorised to work part-time at the beginning of 2010, only 6% moved into full-time employment during 2010, while 20% returned to a full disability benefit (Figure 4.5, Panel A). Among those who worked on a voluntary basis, less than 1% returned to full-time employment (Figure 4.5, Panel B). The flows are relatively similar across different types of disabilities, except that people with mental health problems tend to quit part-time work somewhat more often than people with other health problems.

The large majority of people moving from part-time work to either full-time work or full benefit do so within a year's time. Two-thirds of disability beneficiaries work for less than one year on a part-time basis before moving into full-time employment, while the share is about half for those returning to a full disability benefit (Figure 4.6). People with mental disorders tend to return slightly faster to a full disability benefit than people with musculoskeletal or other health problems, while their return to full-time employment is fairly similar.

Figure 4.5. **Neither part-time work nor voluntary work is a stepping stone into full-time employment**

Percentage share of all disability beneficiaries authorised to work either part-time or on a voluntary basis at the beginning of 2010

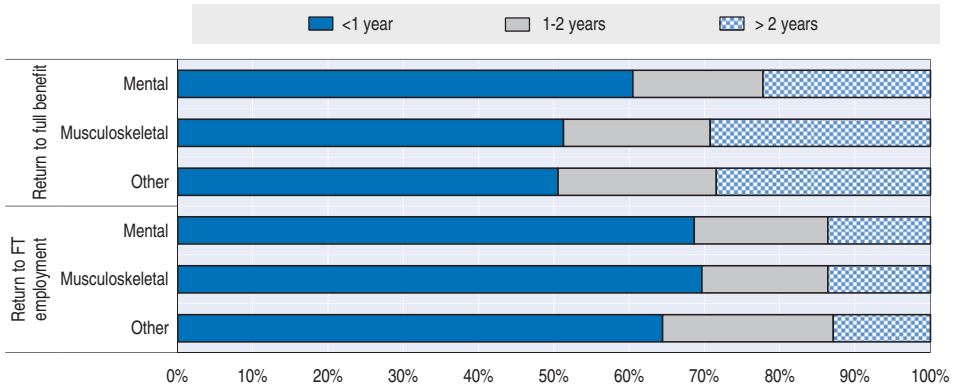


Note: "Other" mainly includes death, retirement and loss of disability benefit eligibility.

Source: OECD calculations based on data from the National Institute for Sickness and Invalidity Insurance.

Figure 4.6. **The large majority of people moving from part-time work to either full-time work or full benefit do so within one year**

Duration of part-time work before returning to full-time work or a full disability benefit, as a percentage of those authorised to work part-time at the beginning of 2010



Source: OECD calculations based on data from the National Institute for Sickness and Invalidity Insurance.

Conclusions and recommendations

Over the past few years, the reintegration of people with health problems into the labour market has become an increasingly important responsibility of the key players in the area, *i.e.* employers, occupational health specialists and mutualities. However, the practical implementation and the co-operation between the different stakeholders are far from optimal. Resources and (financial) incentives to intervene early and actively are not always present in the Belgian system, and the main players sometimes have contradictory roles, generating mistrust among employees and sickness and disability beneficiaries, hence hindering the functioning of the system. Overall, there is relatively little prevention and activation in the Belgian system and the strong focus on controlling the sickness status remains predominant.

Activate mutualities

Mutualities need to play a much more active role in sickness monitoring and management. Despite a relatively high outflow from the Belgian sickness and disability system, mutualities remain quite passive with little focus on return to work. In addition, there is no communication between the mutuality doctor and the company, or the company's occupational doctor. Yet, to make the reintegration of a sickness or disability beneficiary successful, the collaboration of the employer is crucial. To avoid that companies have to deal with many different mutuality doctors depending on their employees' mutuality choice, occupational health specialists ought to be the primary contact for the mutuality doctors and play a prominent role in the reintegration process.

Recommendations

- Strengthen the sickness monitoring and management obligations for the mutualities. For instance, mutuality doctors should see each sickness beneficiary at risk of longer-term incapacity at the end of one month of absence. As in the Netherlands and Norway, a reintegration plan with concrete steps for returning to work and arrangements for evaluating progress could be requested within eight weeks of absence. After the first year of illness, an evaluation report summarising the reintegration efforts and the steps planned for the second year should be submitted together with the medical file to the Board of the National Institute for Sickness and Invalidity Insurance for the evaluation of the person's disability benefit eligibility. All steps should be taken in close co-operation with the

employer, the employee, the occupational doctor and the employee's treating doctor.

- Make mutualities financially responsible for the activation of sickness and disability beneficiaries by tying the budget not only to the number of affiliates, but also to return-to-work outcomes by rewarding those mutualities with a higher exit rate from sickness/disability benefit to work among their clients than the country average and sanctioning those mutualities with a lower exit rate.
- Systematise the dialogue and co-operation between the mutuality doctor and the company's occupational doctor. To overcome the lack of information transmission by employers, mutualities should share the information on all sickness absences with the occupational health services.
- If the occupational doctor and mutuality doctor, together with the employee, come to the conclusion that reintegration in the current company is no longer feasible, the mutuality doctor should contact the regional public employment service (PES) and set up an integration and rehabilitation programme together with the PES caseworker.

Adapt the activation measures

The current activation measures of the mutualities are useful for people who want to stay active, but the majority of sickness and disability beneficiaries, and in particular those with mental health problems, need more intensive and appropriate support than is currently the case. Also, the fact that beneficiaries have to ask permission to work on a part-time or voluntary basis – the mutuality doctor has to approve the type of work, the number of hours and even the working schedule – reflects the thinking that work is bad for their health and that doctors should tell them what is good for them.

Recommendations

- Close down the vocational rehabilitation programme of the National Institute for Sickness and Invalidity Insurance and formalise the co-operation with the regional public employment centres to activate sickness and disability beneficiaries.
- Remove the rule of losing benefit entitlement within six months after participation in a training programme. Beneficiaries should be encouraged to participate in (rigorously evaluated) activation programmes, even if it is uncertain whether this will immediately lead to a job.

Strengthen the financial incentives for employers

Mutualities are not the only stakeholders responsible for the retention or reintegration of people with (mental) health problems in the labour market. Employers, but also occupational health services and GPs, have a crucial role to play. Nonetheless, the financial incentives for employers to adapt the work or workplace to retain or reintegrate people with mental health problems are weak in Belgium. Many companies perceive the costs of sickness management to be higher than the cost of dismissal and recruitment of new staff. In particular, the relatively short period of financial responsibility for sickness payments gives employers little incentives to be actively involved in the reintegration of a sick worker after the guaranteed wage payment period. Strengthening the financial incentives and obligations for employers in workplace and sickness management would increase the demand for risk assessments and prevention programmes, hence stimulating the external services for prevention and protection to increase and improve their supply of services in this field (see Chapter 3).

Recommendations

- Make longer-term sick leave more costly for the employer in order to encourage return-to-work action. This can be done in different ways (some of which are currently being discussed in Belgium), which could be combined in various forms, *i.e. i)* extending the employer-paid period to several months; *ii)* making employers responsible for a certain share, *e.g.* one-third or half, of the costs during the full period of sick leave; *iii)* sanctioning companies with above-average rates of long-term sickness absences; and/or iv) rewarding employers who reintegrate an employee after a long-term sick leave.

Engage occupational health specialists

Employers and mutualities need better supports to fulfil their obligations. The Belgian system of external services for prevention and protection at work with occupational doctors and psychosocial prevention advisors lends itself perfectly to assisting employers in creating a healthy work environment (Chapter 3) but also to helping employers and mutualities with the reintegration of sick employees. However, the co-operation with occupational health services is not optimal, and sometimes very poor.

Recommendations

- Limit regular medical check-ups by occupational doctors to companies with the highest exposure to risk factors to free up time

and resources for the reintegration of workers on long-term sick leave, in particular for those with mental health problems as they are more likely to need individualised support.

- Consider abolishing the possibility to dismiss an employee without a notice period based on medical *force majeur*. Or, if this is not possible, make the control doctor rather than the occupational doctor responsible for this decision in order to strengthen the positive and work-retention-focused role of the occupational doctor.
- Employers should be urged to send the list of employees who are absent for at least four weeks to the occupational doctor, as is currently requested by law but seldom applied. Occupational health specialists should be allowed to contact the sick employees themselves instead of having to wait for their initiative.
- Employers and mutualities should inform employees about the role of the occupational doctor in reintegration in the workplace after a long-term sickness absence.
- Add the reintegration of sick employees to the quality evaluation of external prevention services.
- People with mental health problems not only need support to take up their work again; they also need close mentoring and on-the-job coaching once they are back in the workplace. Psychosocial prevention advisors, together with the confidential counsellor, are ideally placed to provide such continuous support.

Involve general practitioners

GPs are currently hardly involved in the evaluation process of the mutualities and the reintegration of long-term sick/disabled employees in the company, even though their support may often be necessary to encourage them to take up work again. At the same time, sick-listing behaviour varies considerably across GPs and it is not always known that prescribing a period of "rest" is often not a useful answer to a mental health problem, and indeed may even be potentially harmful to the patient.

Recommendations

- Encourage communication and co-operation between GPs, occupational doctors and mutuality doctors through, for instance, a shared electronic information system.

- GPs should be better informed and trained to improve sickness management through, for instance, the distribution and promotion of good practices with respect to: *i)* the prescription of sick leave; *ii)* the importance of the concept of work capacity and the advantages of resuming work; and *iii)* the importance and the role of the occupational doctor.
- Information alone is unlikely to be sufficient to change prescription behaviour. While sanctions (as, for instance, in Norway) are difficult to apply in practice, requesting GPs to explain why the absence period needs to be longer than recommended or prescribed for a particular patient, could be effective.

Notes

1. For unemployed people and certain categories of temporary workers, the mutuality covers sickness benefits from the first day and has to be informed within three days.
2. Severance payments in the strict sense do not exist in the Belgian labour law. Yet, in case of dismissal without notice period, the employee receives a payment equal to the applicable notice period.
3. Sickness and disability benefits cannot be accumulated with notice payments. During the period a person receives such payments, the sickness and disability payments are suspended.
4. Control doctors cannot be at the same time occupational doctors, but some companies offering services for prevention and protection at work also offer services for absence control, *e.g.* Mensura (*www.mensura.be*) and Securex (*www.securex.be*).
5. The National Institute for Sickness and Invalidity Insurance has only information on the sickness absences for which the mutualities pay sickness benefits. For instance, sickness absences lasting for less than one month (14 days for blue-collar workers) are not included in their statistics as these workers receive guaranteed wages from their employers and do not inform their mutuality about their sick leave.
6. Exceptions to the low rate of outflow include New Zealand and the United Kingdom. High outflow rates in these two countries are to a considerable degree a result of the larger proportion of people with short-term health

problems on the disability benefit rolls (and who would be on sickness benefit in other countries).

7. For instance, in the Netherlands, full benefit is granted to people with permanent earnings capacity reduction of at least 80%. Reduced benefits are given to those with a full but temporary capacity reduction or a partial capacity reduction of 35-79%.

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Chapter 5

The disability allowance system in Belgium

This chapter looks at the role and functioning of the Belgian disability allowance system, the scheme for people who have never worked or not long enough to fulfil the disability insurance contribution requirements. It discusses why the outflow to work is negligible and why disability allowances are a trap for young adults.

In addition to the disability insurance benefit, disabled people with a reduced earning capacity are eligible for two types of non-contributory disability allowances. The "income replacement allowance" is targeted at people who have never worked or not long enough to fulfil the disability insurance contributory requirements, while the "integration allowance" compensates people for the additional difficulties they encounter in daily activities due to their disability (for the benefit levels and eligibility criteria see Chapter 1). Such disability allowances are typically granted for life and outflow to work is negligible.

Means-tested disability allowances

The income replacement allowance and integration allowance are granted independently of each other and can be combined with other benefits (such as unemployment benefits, disability benefits, etc.). Both allowances are means-tested and paid by the Federal Public Service for Social Security. By the end of 2010, nearly 160 000 people aged less than 65 received disability allowances (income replacement allowances and/or integration allowances) compared with about 260 000 disability insurance beneficiaries. About 7% of the income replacement allowance beneficiaries and about 18% of the integration allowance beneficiaries also received disability insurance benefits.

A large share of the disability allowance recipients only receives the partial integration allowance (39%; Table 5.1). People receiving such partial benefits often have an income from another source (though below a certain maximum, with the threshold depending on the household situation), such as labour market earnings, spouse's earnings, or one of the several other working-age benefits. Half of the disability allowance beneficiaries receive both an income replacement allowance and an integration allowance, while only 10% of the disability allowance beneficiaries receive just the income replacement allowance.

Although the Federal Public Service for Social Security does not collect information on the type of disorder, a survey of 500 applicants for disability allowances suggests that about 26% of them suffer from a mental or behavioural disorder (Figure 5.1). The majority of disability allowance entrants are women or young people who never entered the workforce (together accounting for 36% of all disability allowance inflows, Figure 5.2), and disability benefit recipients who receive supplementary allowances on top of their disability benefits (21% of all inflows). Other beneficiaries come from social assistance (14% of all inflows), the unemployment benefit system (10% of all inflows), or from the labour market (13% of all inflows).

Table 5.1. **A large share of the disability allowance recipients receives a partial benefit**

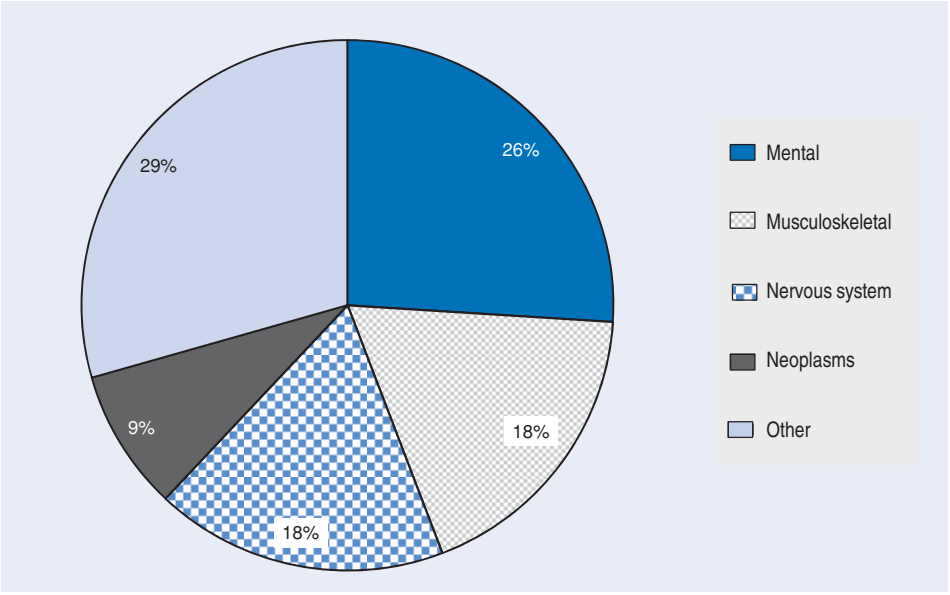
Number of recipients of the income replacement allowance and integration allowance aged less than 65, end 2010

	Numbers	Percentage
Integration allowance only	62 298	39%
Income replacement allowance only	16 354	10%
Both	80 010	50%
Total	*158 662*	100%

Source: Federal Public Service Social Security, Directorate General Disabled People.

Figure 5.1. **Mental disorders account for one quarter of all disability allowance applications**

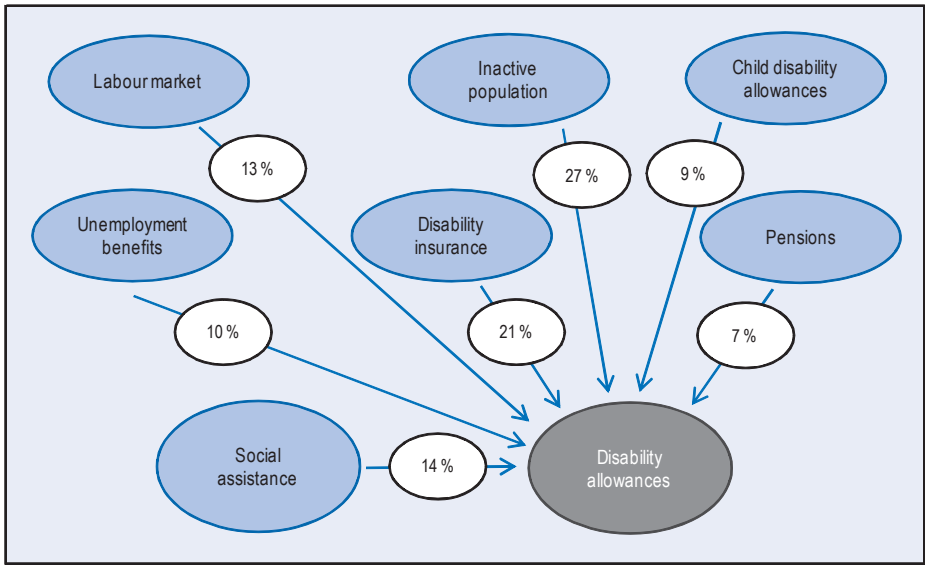
Inflow into disability allowances by health condition as a percentage of total inflows for persons aged 21 to 65, 2008



Source: Federal Public Service for Social Security, Directorate General for Disabled People.

Figure 5.2. **A large share of the disability allowance entrants has never worked**

Inflows into disability allowances, in percentages, 2009



Source: Federal Public Service for Social Security, Directorate General for Disabled People.

Despite clear distinctions in eligibility criteria for disability benefits and disability allowances, some people are being shifted around between both systems. In principle, disability benefits are social insurance benefits for workers satisfying the minimum contributory requirements of at least six months of employment or 120 days of actual work being covered. If the work-capacity assessment reveals, however, that the disability occurred *before* the person started working, the case is referred to the disability allowance system. In this case, a *medical* assessment rather than a *work-capacity* assessment determines eligibility for benefits, and people who were considered disabled in the disability benefit system but transferred to the disability allowance system can still be rejected for the latter. Most of these cases are then brought to court, which typically decides in favour of disability insurance benefits.

There is no activation of disability allowance beneficiaries

Employment activation is not imbedded in the disability-allowance system and outflows for reasons other than death or retirement are negligible (less than 1% of the disability allowance stock). There is no co-operation between the Directorate General for Disabled People of the Federal Public Service for Social Security, which is financially responsible for disability allowances, and

the regional employment offices, which are responsible for the employment support for people with mental health problems.[1] Disability allowance beneficiaries with remaining work capacities who would like to work can contact the regional employment offices, but they are neither encouraged nor obliged to work by the Federal Public Service for Social Security.

Disability allowances are a trap for young adults

Parents of children aged 0 to 21 with disabilities, including behavioural or emotional disorders, can apply for a child benefit supplement from the disability allowance system. The benefit amounts depend on the degree of difficulties the child experiences in daily life and range from EUR 77 to EUR 517 in addition to the regular child benefits.[2] The eligibility evaluation is carried out by a medical doctor of the Directorate General for Disabled People of the Federal Public Service for Social Security, the same department responsible for the medical assessment for adult disability allowance beneficiaries.

For young people benefiting from the child benefit supplement for disabled children, there are strong disincentives to start working when they turn 18, as this means a re-evaluation of their eligibility. Only when they work in a sheltered workplace, in paid employment with a maximum of 240 hours per quarter, or as an intern with gross earnings below EUR 510 a month, is it possible for their parents to continue receiving the child benefit supplement. As a result, very few take the risk of losing their benefit entitlements and nearly all child disability beneficiaries directly move into the disability allowances system once they turn 21. Since there is no rehabilitation or employment support imbedded in the disability-allowance system, most youth will never leave the system for work and remain for a lifetime dependent on benefits.

Conclusions and recommendations

The disability allowance system is built around the principle of providing benefits for people who cannot be expected to work. Accordingly, potential benefit recipients are assessed in terms of their incapacities and are not assumed to look for a job (in a reduced capacity) or improve their employability as a condition for benefit entitlement. As the outflow from the disability allowance system (other than through death and retirement) is nearly zero, beneficiaries are highly likely to spend a lifetime on benefits, often not high enough to keep them out of poverty. This is a particular concern for the young. Yet, many mental disorders are fluctuating over time and the

symptoms can be reduced with appropriate treatment. For these reasons, full and permanent disability allowances are not the best solution for this group.

Recommendations

- Restrict permanent disability allowances to people with the most severe mental disorders and introduce temporary payments with reassessments at periodic intervals for those with remaining work capacity.
- Broaden the disability allowance assessments to look at what work capacity clients still have. Consider adopting a multidimensional assessment framework as used in other OECD countries, *e.g.* Australia, Denmark and the Netherlands (OECD, 2010).
- Strengthen reintegration measures in co-operation with the regional public employment services, accompanied by participation requirements, to help people with mental disorders access the labour market.
- Avoid the automatic transition from child disability benefits to disability allowances and eliminate the strong disincentives to start working for child disability allowance beneficiaries once they finish compulsory education.

Notes

1. Mental disorders are not recognised as disabilities by the regional offices for people with disabilities – *i.e.* AWIPH (*Agence Wallonne pour l'Intégration des Personnes Handicapées*) in Wallonia, PHARE (*Personne Handicapée Autonomie Recherchée*) in Brussels, and VAPH (*Vlaams Agentschap voor Personen met een Handicap*) in Flanders – which are responsible for employment policies for people with disabilities (except in the case of Flanders, see Chapter 5). People with mental disorders thus depend on the public employment services for employment support.
2. The amounts apply to 2012 and are taken from the Department of Child Benefits for Employees (*http://onafts.fgov.be*).

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Chapter 6

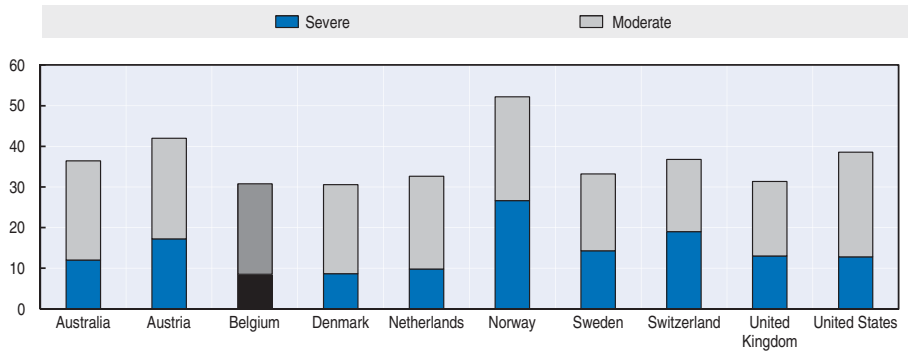
Belgium's public employment services

This chapter looks at the role of public employment services (PES) in dealing with mental disorders among their clients. It starts by describing how the PES recently became aware of the issue and the active labour market programmes that are gradually being developed to support job seekers with mental health problems. The chapter discusses the mechanisms the Flemish PES developed to identify and address the needs of people with mental health problems as well as the programmes targeted at long-term unemployment beneficiaries with multiple problems, including mental disorders. The chapter ends with a short discussion of the recent outreach by the Flemish PES to beneficiaries of the social assistance and disability benefit systems.

Disability benefits are only one of several working-age benefits for people with a mental disorder. Not everyone will fulfil the strict eligibility criteria of the disability system, and many people are not even applying for disability benefits because of stigma considerations. Data from the Belgian Health Interview Survey illustrate that about one third of the unemployed have a severe or moderate mental disorder (Figure 6.1) and the prevalence is even higher among long-term unemployed (OECD, 2012). On the one hand, workers with mental illnesses are more likely to lose their jobs and become unemployed, and, on the other hand, unemployment is bad for mental health, with a particularly strong initial "shock" effect – following some mid-term adjustment – resulting in a detrimental impact on long-term unemployment (OECD, 2012). It is thus crucial for employment services to identify people with mental health problems early on and support their specific needs to prevent labour market detachment (and an eventual move onto disability benefits).

Figure 6.1. **Prevalence of mental disorders is high among unemployed people**

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



Source: National health surveys. Australia: National Health Survey 2007/08; Austria: Health Interview Survey 2006/07; Belgium: Health Interview Survey 2008; Denmark: National Health Interview Survey 2005; Netherlands: POLS Health Survey 2007/09; Norway: Level of Living and Health Survey 2008; Sweden: Living Conditions Survey 2009/10; Switzerland: Health Survey 2007; United Kingdom: Adult Psychiatric Morbidity Survey 2007; United States: National Health Interview Survey 2008.

Awareness of mental health problems among the unemployed has risen

Until very recently, there was a considerable lack of awareness of the importance of mental health problems among unemployment beneficiaries in Belgium – as in other OECD countries – despite the fact that the majority of people with mental disorders remain on unemployment benefits. In the case of Flanders, it was only in 2006, when the responsibility for employment policies for disabled people was transferred from the Flemish agency for people with a disability (VAPH) to VDAB, that the awareness of mental disorders rose. The

transfer not only generated increased attention to disabilities, but also revealed a group of VDAB clients with serious non labour-market-related problems that greatly hindered, or made even impossible, their re-employability. A relatively large subgroup of them turned out to have severe medical, mental, psychological or psychiatric problems, the so-called MMPP group. This group could theoretically be classified under job seekers with a work disability, but not all had been labelled as such. By identifying them, some could enter specialised active labour market measures, but a large share of the MMPP group was not yet job-ready and first needed other types of services. No such services had been transferred from VAPH, however, as the latter does not recognise mental disorders as a disability. VDAB was thus obliged to create new activation services to prepare job seekers with severe mental disorders for employment. In 2009, they started an experiment in co-operation with external partners to provide intensive activation programmes combining care and employment support (the co-operation is described in detail below). At the same time, they improved their screening process and active labour market measures for people with more moderate mental health problems. Currently, VDAB is developing the legal framework to move away from the experimental phase by 2015.

In Brussels and Wallonia, employment policies for disabled people remain in the hands of the respective agencies for people with disabilities, *i.e.* PHARE and AWIPH. Yet, as VAPH in Flanders, these agencies do not recognise mental disorders as disabilities; people with mental disorders are thus not eligible for their employment support measures and depend on the regional public employment centres instead for such supports. Increased attention to mental ill-health in Flanders also led to better awareness in the other two regions. Forem in Wallonia set up similar experiments for the activation of people with more complex social needs, including people with severe mental health problems, in two large cities (Liège and Namur) and there is a proposal on the table to make people with mental disorders an official target group for employment services to make more resources available. The long period without a federal government in 2010-11 delayed the policy implementation process, however. Currently, it is still the federal government which decides about the target groups of the regional public employment services, but the institutional reform (to be implemented after June 2014) will allow regions to define their own target groups.

In the following sections, the screening and activation policies of the Flemish public employment service, VDAB, will be described. However, it should be noted that regional differences in unemployment and activation measures for job seekers are substantial in Belgium (see Box 6.1 for a short discussion). Since a description and comparison of the three regional employment services for people with mental ill-health would become too

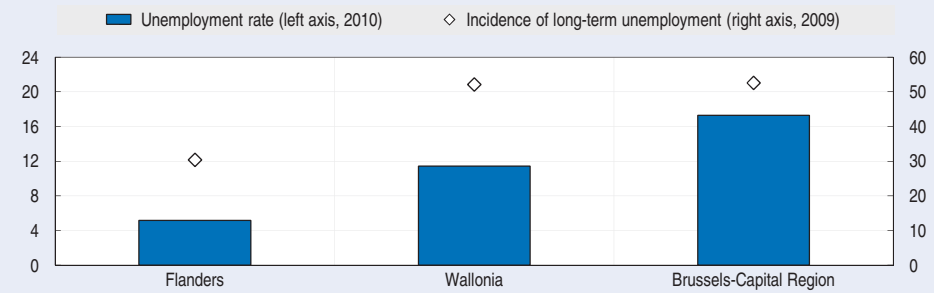
long for the purpose of this report, we have opted for a detailed discussion of the most advanced system in terms of support measures for people with mental health problems, *i.e.* VDAB in Flanders. However, given the much higher share of long-term unemployment in Brussels and Wallonia (see Box 6.1) and thus higher risk for mental disorders, the need for better support measures for people with (moderate) mental health problems is probably much higher those two regions. As such, the issues discussed in this section are all the more relevant for Brussels and Wallonia.

Box 6.1. **Regional differences in unemployment and activation**

Regional differences in unemployment as well as activation measures for unemployed people are substantial. In 2010, the unemployment rate was 5.2% in Flanders compared with 11.4% in Wallonia and 17.3% in Brussels-Capital Region (see figure below). In the latter two regions, the incidence of long-term unemployment (52% in 2009) is considerably higher than in Flanders (30%). More than one third of the job seekers had not been offered any active measure within a year in Wallonia compared with 15% in Flanders and 26% in Brussels-Capital Region (see table below). 20% of the Walloon job seekers had not even been offered placement services within a year; the shares being 12% and 15% in Flanders and Brussels-Capital Region, respectively. Brussels-Capital Region devotes the least resources to active labour market measures (about EUR 1 900 per unemployed person compared with EUR 3 200 in Wallonia and EUR 4 300 in Flanders). While the three regions (Flanders, Wallonia and Brussels-Capital Region) are responsible for employment policy, training and education policy falls under the responsibility of the Communities (Flemish Community, French Community and German Community). Actiris thus does not offer training programmes themselves but have to refer job seekers to VDAB or Forem. The National Employment Office spends an additional EUR 3 700 per unemployed person, but it is unclear how the federal money is divided over the regions.

Regions can impose sanctions for insufficient job-search efforts or availability,[1] but since they are not financially responsible for benefit payments, the National Employment Office depends on the information transmission from the regions. Flanders tends to impose more regularly sanctions on unemployment beneficiaries who are not actively looking for a job (21% of the unemployed job seekers in the region; see Table below) than Wallonia (15%) and Brussels-Capital Region (12%). The National Employment Office can check on job search and availability itself (6% of all unemployed job seekers were sanctioned in 2011), but intervenes only at a very late state – after 15 months of unemployment for those aged under 25, or 21 months of unemployment for those aged between 25 and 49 (Venn, 2012).[2] Mental ill-health (as well as other health problems) is a valid reason for refusing job offers, and older unemployed (58 years and older) are exempted from all job search and availability requirements.[3] The foreseen institutional reform (to be implemented after June 2014) intends to devolve the full responsibility for checking on job-search to the regional public employment services, while keeping the payment of unemployment benefit at the federal level. However, it is still not clear how the regions will be made financially responsible for their activation policy.

There are large differences in unemployment across regions in Belgium



Source: OECD Database on Regional Statistics.

Active labour market policies differs substantially across regions

Active labour market policies at the regional and federal level: timely intervention, sanctions and expenditure

	No placement serivces within 12 months (2008)[a]	No active measures within 12 months (2008)[b]	Sanctions as % of jobseekers (2011)	Expenditures (in EUR) per unemployed person (2009)[c]
Flanders	12%	15%	21%	4 256
Wallonia	20%	36%	15%	3 224
Brussels-Capital Region	15%	26%	12%	1 923
Federal level	-	-	6%	3 648
Belgium	**16%**	**26%**	**16%**	**6 988**

a. The share of job seekers who became unemployed in month X, who were still unemployed in month X+12 and who had not received any placement services by then over all job seekers who were still unemployed in month X+12.

b. The share of job seekers who became unemployed in month X, who were still unemployed in month X+12 and who had not received any active measures by then over all job seekers who were still unemployed in month X+12.

c. Expenditure on active measures includes categories 2-7 as defined in OECD (2011), *OECD Employment Outlook 2011* (Statistical Annex, Table K).

Source: OECD calculations based on data from the Federal Planning Bureau (*www.be2020.eu*) and National Employment Office (*www.rva.be*).

1. The penalty for refusing a suitable job, not attending the PES without sufficient justification, not attending a job interview after a referral from the PES or stopping or failing an integration course due to the attitude of the unemployed is a suspension of benefits for 4-52 weeks. The typical sanction is 10-14 weeks. The penalty for refusing to undertake an integration course proposed by the PES is total suspension of benefits (Venn, 2012).
2. At that moment, the job seeker is invited by the Federal National Employment Office to evaluate their job-search efforts. If the efforts are deemed sufficient, another interview will be held 16 months later. If not sufficient, an action plan will be drawn up detailing job-search efforts required, which is checked at an interview 4 months later. A negative evaluation at that moment results in a temporary reduction or suspension of benefits. Only when an unemployed person refuses a second suitable job offer in the 12 months following the suspension or reduction of benefits, do they lose their right to benefits and do not regain their rights until after working for a sufficient number of days.
3. The age limit was 50 years until December 2011.

Intensive assistance for people with mental disorders

At the moment of intake, job seekers in Flanders are systematically assessed for problems which may hinder their re-employment.[1] Caseworkers not only pay attention to employment-specific competences and qualifications, job-search behaviour, social and communicative skills, disabilities, and secondary conditions (such as mobility, childcare, inactivity trap), but also to mental health problems. An interview can be requested at any time during the unemployment spell if there is an indication of a problem. In case the VDAB caseworker believes there is a more severe mental health problem, the client is sent for a diagnosis to a VDAB psychologist or an external employment research centre specialised in in-depth multidisciplinary screening (*Gespecialiseerde Arbeidsonderzoeksdienst* – GA).[2] Currently there are 17 non-profit GA centres in Flanders and they are financed by VDAB. In 2011, about 5 500 persons, or 2.8% of the total number of job seekers in Flanders, underwent an in-depth multidisciplinary screening by VDAB or an external GA centre.

Self-motivated job seekers with a good chance of finding a job receive some initial guidance and information as well as systematic referrals to appropriate vacancies, while job seekers with a more problematic profile or with labour market disadvantages that were identified during the assessment (such as low education, lack of experience, mental health problem, etc.) receive intensive assistance. VDAB offers a wide range of active labour market programmes, including job-search assistance, (on-the-job) training, education, etc. At any point in time, the guidance and support can be intensified depending on the needs of the job seeker or the opinion of the caseworker. At latest after nine months of unemployment (six months for job seekers aged less than 26), an individual action plan is set up and an intensive activation programme is started.

Job seekers with an indication of a work disability,[3] including those with mental health problems that have been revealed through (in-house or external) screening, receive specialised support in their job search. Besides its internal active labour market measures, VDAB also works together with specialised centres for the training, guidance and intermediation of job seekers with a work disability (*Gespecialiseerde Opleidings- en Begeleidingsdienst* – GOB). As is the case with the GA centres, the non-profit GOB centres are financed and controlled by VDAB. Currently there are 12 such centres operating in Flanders and they offer services such as vocational training, job coaching, on-the-job training (with a maximum of 800 hours) and supported employment (maximum 12 months and with zero costs for the employer).

In addition, job seekers with an indication of a work disability can apply for special employment support measures (*Bijzondere Tewerkstellingsondersteunende Maatregelen* – BTOMs), such as wage subsidies, adaption of the work place, transport subsidies or sheltered employment. These BTOMs are also open for people with a disability who are still in employment. The decision about whether a job seeker can benefit from a BTOM or not is taken by VDAB and is typically based on a list of disabilities (about 70% of the cases),[4] but can also be taken on the basis of the GA screening (about 25% of the cases) or multidisciplinary advice (minor fraction). The BTOM can apply indefinitely, for a certain period, or for two years with obligatory guidance towards paid employment.

Participation is frequent, but outflow to work is low

Overall, job seekers with identified mental health problems tend to be over-represented in active labour market programmes in Flanders. About 13% of the job seekers registered at VDAB are flagged as having a work disability (Table 6.1, Panel A, last row). Only a minority of them have severe medical, mental, psychological or psychiatric problems (MMPP group; 3.5% of all job seekers) or have been diagnosed with a mental disorder (1.6% of all job seekers). Yet, both groups are over-represented in the active programmes. Even within the group of job seekers with a work disability, those with a mental disorder are much more likely to receive wage subsidies or participate in sheltered employment – 29% and 33% of the BTOM beneficiaries are people with a mental disorder compared with a share of 12% in the total number of job seekers with a work disability (Table 6.1, Panel B, second column).

Despite their over-representation in active labour market programmes, job seekers with disabilities have more difficulties in making a successful transition into work. VDAB analysed the flow out of unemployment after participation in an active labour market programme, comparing the outcomes of people with and without disabilities, while controlling for a number of other factors (such as sex, age, education, migrant, social assistance beneficiary, etc.) to isolate the effect of disability on outflow (Samoy, 2012). Figure 6.2 illustrates that after 12 months, 52% of people with disabilities are still on unemployment benefits, compared to 41% of people without disabilities.

Table 6.1. **Participation of people with disabilities in active labour market programmes in Flanders**

Panel A: Regular active labour market programmes, cumulative numbers, 2011

	Job seekers with a work disability	Job seekers with a mental disorder	Job seekers with MMPP	All job seekers
	Number of persons participating in each measure			
Guidance	13 477	2 916	5 332	74 193
Training	9 878	2 246	2 197	71 776
Intensive support	23 852	5 137	6 106	167 298
	Share in total number of participants in each measure			
Guidance	18.2	3.9	7.2	100
Training	13.8	3.1	3.1	100
Intensive support	14.3	3.1	3.6	100
	Share in total number of job seekers			
Job seekers	13.2	1.6	3.5	100

Panel B: Additional measures for people with a disability, cumulative numbers, 2011

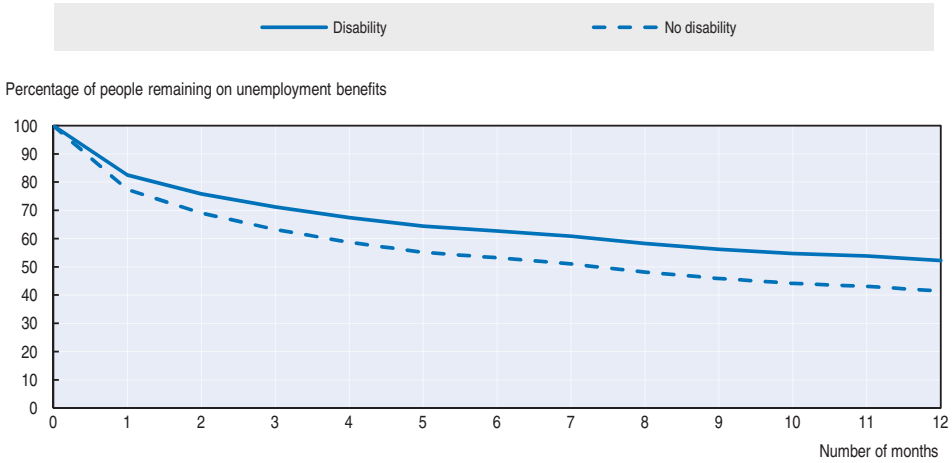
	Job seekers with a work disability	Job seekers with a mental disorder	Job seekers with MMPP
	Number of persons benefiting from each measure		
BTOM measures	24 113	6 896	3 332
Wage subsidies	21 501	6 191	2 960
Sheltered employment	13 030	4 308	2 719
	Share in total number of beneficiaries of each measure		
BTOM measures	100	28.6	13.8
Wage subsidies	100	28.8	13.8
Sheltered employment	100	33.1	20.9
	Share in total number of job seekers with a work-disability indication		
Job seekers	100	12.3	19.1

BTOM: Special employment support measures (*Bijzondere Tewerkstellingsondersteunende Maatregelen)*; MMPP: Medical, mental, psychological or psychiatric problems

Note: Job seekers with a work disability (first column) are people with an important and long-standing problem for participation in working life, due to the interaction of impairments of a mental, psychological, physical or sensory nature, limitations in the performance of activities, and personal or external factors. Job seekers with a mental disorder (second column) are diagnosed as such by a medical doctor according to an internationally recognised psychiatric classification. Job seekers with MMPP (third column) are people with severe medical, mental, psychological or psychiatric problems (but are not necessarily diagnosed as having a mental disorder). All job seekers with a mental disorder are also labelled as having a work disability, but this is not the case for job seekers with MMPP since some of the latter are not yet ready for the labour market and would, as such, not benefit from special support measures offered to people with a work disability.

Source: OECD calculations based on data from the Flemish Public Employment and Vocational Training Service.

Figure 6.2. **People with disabilities stay longer on unemployment**



Note: The outflow rates are controlled for seven characteristics to single out the effect of disability: education, age, sex, migrant, social assistance beneficiary, cohorts 2003, 2005 and 2007, and whether the person had already been a job seeker in the past four years.

Source: Calculations by Samoy, E. (2012), "Handicap en Arbeid, Deel II: Beleidsontwikkelingen", Update 2012, Vlaamse Overheid Departement Werk en Sociale Economie, based on data from the Flemish Public Employment and Vocational Training Service.

A new programme for people with severe mental disorders

In 2009, VDAB started a pilot project of activation guidance for people with severe mental health problems (MMPP-group) who are not yet ready for employment but who have remaining working capacities and are willing to co-operate (participation is voluntary). The activation guidance programme is financed by the Flemish Government and supports job seekers with MMPP in overcoming social and psychosocial barriers to finding and keeping a job, lasting for maximum 18 months. The main provider of activation guidance is a non-profit centre specialised in the activation of MMPP job seekers (*Gespecialiseerde Traject Bepalings- en Begeleidingsdienst* – GTB), which co-ordinates the co-operation between the health care and welfare sector (see Box 6.2). VDAB contracts GTB on a yearly basis and establishes each year the minimum number of participants (total and new participants), as well as the outflows to the labour market GTB has to reach (cases are weighted by degree of difficulty and some can count for more than one).

Box 6.2. **Co-operation between the employment, health and welfare sector**

Three players closely co-operate in the activation guidance of a job seeker with severe medical, mental, psychological or psychiatric problems:

- *The GTB job coach* – who is also the case manager and has control over the whole process;
- *The health coach from the mental health sector* – typically a psychologist working in a psychiatric hospital or centre for mental health;
- *The empowerment coach from the welfare sector* – typically from a non-profit organisation with experience in sheltered employment or employment care.

The partners in the health and welfare sector are selected by VDAB through public procurement and are required to appoint a health coach and an empowerment coach responsible for working with GTB.

After a job seeker has been selected by the VDAB for the activation guidance programme, the GTB job coach sets up an individual action plan together with the job seeker and brings the person in contact with the health coach and the empowerment coach who are responsible for identifying the right services in the health sector and welfare sector respectively:

- The *health coach* focuses on the medical, mental, psychological or psychiatric problems and provides rehabilitation and training in, for instance, self-confidence, handling stress, assertiveness, getting the self-image right (dealing with under/overestimation), etc. Individual or group therapies are provided in-house or by partner providers.
- The *empowerment coach* of the welfare sector focuses on the psycho-economical, psychosocial or social impediments and deals with issues such as mobility, personal budget, housing, leisure activities, etc. Also the empowerment coach works either on an individual or group basis.

During the entire process, the GTB job coach makes sure that the activation guidance has a focus on work. All services are financed by the Flemish Government and free of charge for the job seeker.

In 2011, about 5 500 people with an indication of severe medical, mental, psychological or psychiatric problems were screened by VDAB or by an external GA (Table 6.2). More than half of them were labelled as MMPP, *i.e.* those who were advised to start with the MMPP activation guidance programme (28%) or employment care (16%),[5] and those who have no remaining work capacity (15%). Nearly one third of them was considered ready for regular employment and could start with (specialised) active labour market programmes. Job seekers without remaining work capacity should in principle be suspended from the unemployment benefit system and apply for disability benefits, but this is not done in reality as it is socially unacceptable – not all unemployed people with mental health

problems are eligible for disability benefits, and even if they are, the transfer onto disability benefits is long and people may temporarily end up without benefits, or on the lower social assistance benefit.

Table 6.2. **Activation of job seekers with severe mental health problems in Flanders, 2011**

	Advice after screening		Advice after completion of MMPP activation guidance	
	Number	Percentage	Number	Percentage
MMPP activation guidance	1 543	28%	-	-
Employment care	912	16%	96	24%
Sheltered employment	589	11%	47	11%
Regular employment	1 674	30%	104	27%
No remaining work capacity	813	15%	152	38%
Total	5 531	100%	399	100%

MMPP: Medical, mental, psychological or psychiatric problems.

Source: OECD calculations based on data of the Flemish Public Employment and Vocational Training Service.

Participation is voluntary, but about 80% of those who were advised to follow the 18-months activation guidance programme effectively started in 2011. Since September 2009, 400 persons completed the programme: 27% were considered ready for paid employment, while for 38% of the participants it was concluded that they would not be able to work either in regular employment or in a protected environment (Table 6.2). So far, only 36 persons (33%) of those that participated in the MMPP activation guidance programme effectively found a job in the regular labour market. For 2012, VDAB also intends to measure other success factors, such as outflow to employment care, voluntary work, treatment for mental health problem, improved self-awareness, etc. While a success rate of 33% seems low at first sight, it should not be forgotten that these people are the most difficult group to activate and have often been unemployed for many years. At the same time, the fact that only one third of those people who are considered ready for paid employment effectively find a job also indicates significant reluctance on the part of Belgian employers to hire an unemployed worker with mental ill-health.

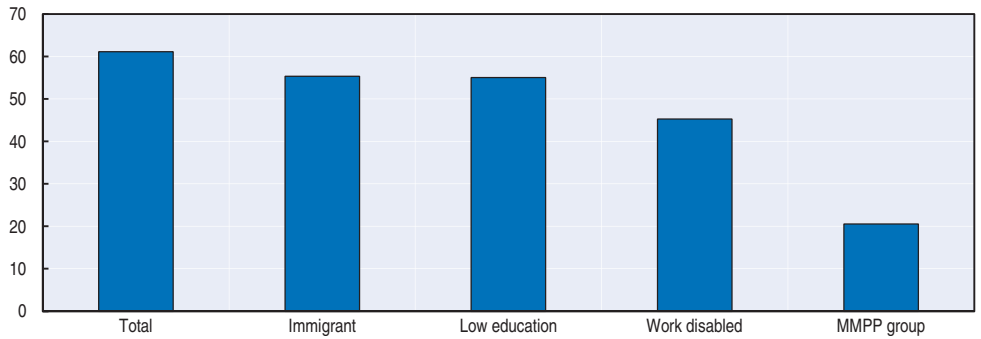
Few job seekers with severe mental health problems effectively move into employment. Barely 21% of job seekers with MMPP who participated in an active labour market programme found a job within six months (Figure 6.3). Job seekers with a "work-disability indication" do considerably better, with 45% of them working within six months, but they do less well

than other risk groups, such as low-educated job seekers and immigrants (55% of them found a job within six months).

One element limiting the use of regular employment for people with severe mental health problems is the lack of flexibility in the Belgian labour law for part-time work and a variation of working hours over time. In many cases, people with mental disorders would benefit from a gradual increase in working hours over time, but each change in working hours would require a change in the job contract. Also, the minimum duration of part-time work is one-third of a full-time job (*i.e.* 3 hours per day and 13 hours per week), which is not always possible for someone with a severe disorder.

Figure 6.3. **Few job seekers with severe mental health problems move into employment**[a]

Percentage of people who are working six months after finishing an active labour market programme, 2011



MMPP: Medical, mental, psychological or psychiatric problems.

a. Employment includes sheltered employment and employment care.

Source: Flemish Public Employment and Vocational Training Service.

Outreach to social assistance and disability benefit recipients

In 2011, VDAB initiated a collaboration – with financial support from the Flemish Government – with the public social welfare centres (OCMWs) and the National Institute for Sickness and Invalidity Insurance and its mutualities to open its programmes to social assistance and disability benefit recipients, and in particular those with mental health problems. This co-operation is promising, but it will require a clear change in mindset, especially among the mutuality doctors. In particular, disability benefit recipients who register at the regional public employment service automatically lose their disability benefit entitlement, unless they receive the explicit agreement of the mutuality doctor (INAMI, 2010). So far, co-

operation is limited – only 60% of the 230 places that were opened for social assistance and disability benefit recipients at VDAB were filled (Vlaams Parlement, 2012) – though well-received among the different stakeholders. Finally, VDAB has created a platform in which the different sectors (social assistance offices, National Institute for Sickness and Invalidity Insurance and the health sector) exchange information and develop best practices.

Conclusion and recommendations

The awareness of mental disorders among public employment services (PES) has risen in recent years and promising pilot programmes for people with severe mental health problems have been developed in close co-operation with the health and welfare sectors. It is unclear, however, to what extent people with mild and moderate mental disorders receive appropriate support, even though their share among unemployment beneficiaries is much larger than those with severe mental disorders. To some extent, the increased attention to mental health problems in the assessment of job seekers in the Flemish region is likely to improve the early detection of more moderate mental disorders. Yet, close co-operation between the PES and the health sector would be beneficial for all job seekers with mental health problems, not only for those with severe mental disorders as is currently the case. More co-operation and willingness from the side of employers to hire and keep workers with mental ill-health is also crucial to improve the labour market integration of this group.

Recommendations

- Develop the legal framework for close co-operation between the PES and the health and welfare sector, and provide sufficient funding to open joint labour market programmes for people with moderate mental health problems who are receiving unemployment benefits or other benefits (such as social assistance benefits, sickness and disability benefits, or disability allowances).
- Undisclosed mental health problems among job seekers could be wrongly interpreted as a lack of motivation (*e.g.* not showing up at a job interview, quitting training, etc.), increasing the risk of being sanctioned. While sanctions (or the threat of a sanction) are useful to motivate job seekers to look actively for a job, repeated sanctions may be an indication of an underlying mental health problem. These people should receive more attention from caseworkers.
- Open programmes to people with mental health problems who are still employed, but at risk of losing their job.

- Make the labour law more flexible to facilitate a gradual return to work and part-time employment. A (temporary) change in hours should not imply a contractual change.

Notes

1. Before 2010, such assessment would take place within the first 6 months of unemployment for job seekers under age 50, but not necessarily at the intake. To improve the early detection of problems, job seekers are now systematically assessed at the moment of intake. The assessment can be repeated at any time during the unemployment span if there is an indication of a problem.

2. VDAB psychologists have various screening instruments at their disposal: interview, paper questionnaires (*e.g.* symptom check list, coping strategies, general personality), intelligence tests (*e.g.* Wechsler Adult Intelligence Scale; WAIS), computerised tests (*e.g.* cognitive skills, memory and learning abilities, personality), as well as assistance for the interpretation of medical information.

3. VDAB defines a "work-disability indication" as "every important and long-standing problem for participation in working life, due to the interaction of impairments of a mental, psychological, physical or sensory nature, limitations in the performance of activities, and personal or external factors". Unemployment beneficiaries are labelled as having a work disability if (1) they are recognised as having a disability by VAPH, the National Institute for Sickness and Invalidity Insurance, Work Injury Fund, or Disability Allowances system; (2) they come from the special education system; or (3) they have a certificate from a recognised VDAB service or medical doctor.

4. The list of disabilities is based on the internationally recognised classifications DSM-IV-TR (Diagnostic and Statistical Manual of Mental Disorders, fourth edition, text revision) and ICD-10 (International Classification of Diseases, tenth revision), and includes mental disorders.

5. Employment care is unpaid work for people who either cannot yet or can no longer work in regular or sheltered employment. It provides work-based activities in a productive or service environment, and is situated on a continuum of care and employment, where the emphasis can lean over to either depending on the demand and possibilities of the person.

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Chapter 7

The mental health system in Belgium

This chapter discusses the effectiveness of the mental health care system in Belgium in providing adequate treatment to persons with mental disorders, subsequently looking at the challenges for and resource capacity in primary health care and the accessibility of specialist mental health care services. It also discusses the ongoing major reform in the mental health care sector and the potential role for the employment sector to improve the co-ordination between, and the integration of, the mental health care system and the employment system.

Many mental disorders are persistent and show high rates of recurrence. Yet, most of them can be treated by reducing the symptoms and stabilising the conditions, even though they cannot be cured in the sense that the cause of the disorder is eliminated. While there is also evidence that adequate treatment improves work outcomes, clinical improvements do not automatically or fully translate into better work functioning, increased well-paid employment, or in getting off disability rolls (Frank and Koss, 2005). Co-operation between the mental health sector, the employment services and employers is therefore necessary to raise the labour market participation of people with a mental disorder.

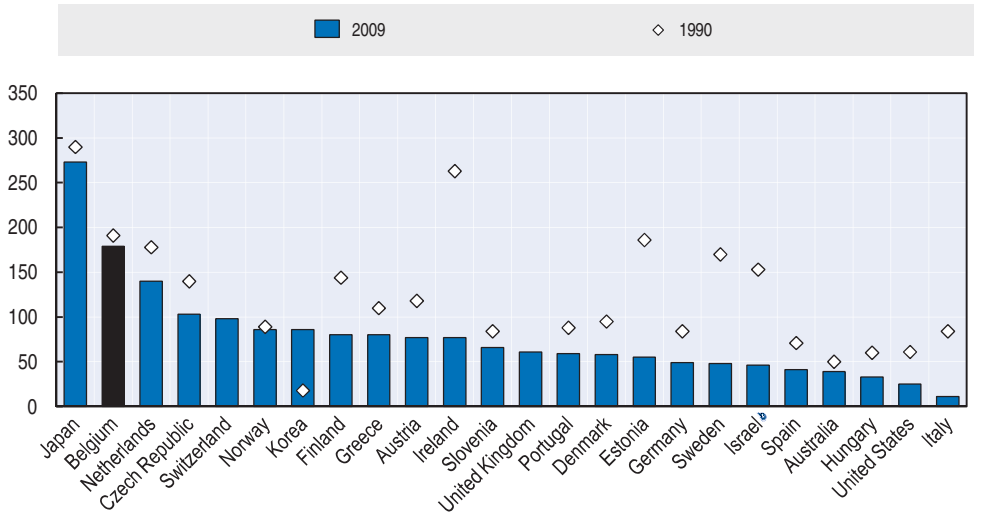
A major re-organisation of the mental health sector

Mental health care in Belgium is administered both at the federal and community level. The federal government is responsible for the organisation and financing of psychiatric hospitals, psychiatric services in general hospitals, psychiatric care facilities and sheltered living (*i.e.* tertiary care), while each of the three language communities is in charge of the organisation and financing of the centres for mental health (*i.e.* secondary care). Primary care is offered by GPs, student guidance centres and welfare centres. However, co-ordination and co-operation across these different administrative levels and actors are not always transparent and often lacking. The system has become even more complex as different stakeholders, including primary-care providers, have taken their own initiatives to address the increasing demand for mental health services and the lack of care continuity. As a result, there is frequent overlap between the services offered by the welfare centres (primary care) and centres for mental health (secondary care), but also between secondary-care and tertiary-care providers, while a clear overview of the treatment possibilities is lacking.

A major reform of the mental health sector is being undertaken to reorganise the sector towards a more consolidated and continuous care system. In the first place, the reform implies a shift away from a hospital-based service system towards a community-based service system. This "deinstitutionalisation" process is a welcome change, but comes much later than in most other OECD countries (for a short overview, see OECD, 2012). With about 185 psychiatric inpatients beds per 100 000 inhabitants in 2010, Belgium has one of the highest ratios in the OECD (only Japan has a higher ratio; Figure 7.1), despite the fact that community care has well-proven advantages over hospital-based care in terms of improving the social inclusion of people with mental disorders. Other aspects of the mental health reform include improved co-ordination and consolidation between the various levels of mental health care, more attention to prevention, early detection and early intervention, and better co-operation with the education and, since very recently, employment authorities (see Box 7.1).

Figure 7.1. **Belgium has the second highest ratio of psychiatric beds in the OECD**

Number of psychiatric inpatient beds per 100 000 population, 1990-2009[a]



a. The data for Australia refer to 1991 and 2006. The data for 1990 refer to: 1991 for Germany and the United States; 1993 for Finland, Greece and Japan; and 1994 for Hungary.

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

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

Box 7.1. **Large reform of the mental health sector is ongoing in Belgium**

In 2002, all ministers responsible for public health, health policy and social affairs – seven ministries were involved, at the federal, regional and community levels – signed a joint declaration to make mental health care more demand-oriented in the form of care networks and care circuits where different players co-operate to provide continuous care based on the needs of people with mental health problems rather than focussing on the supply of services of a particular institution (article 11 of the federal hospital law). Across Belgium, several projects were started (*e.g.* 45 projects in Flanders), but a global framework was lacking.

To improve the implementation of the care networks and circuits, a guide was published by the inter-ministerial conference in 2010, describing the structure and goals of a care network, the (financial) support available from the federal government and the legal implications.[1] In particular, the guide states that each care network has to fulfil five functions: 1) activities on prevention, promotion of mental health care, screening and diagnosis, and early detection and intervention, all in close co-operation with primary care (*i.e.* GPs, welfare centres and home care); 2) multidisciplinary mobile teams for intervention at home to stimulate swift and easy-accessible care; 3) rehabilitation teams working on recovery and social inclusion (including work – the labour ministries were recently invited to join the reform discussions to stimulate the co-operation between the mental health and employment sector); 4) intensive hospital treatment with follow-up after dismissal; and 5) sheltered living. To finance the care network,

psychiatric hospitals and psychiatric services in general hospitals are allowed to reallocate resources for hospital beds towards the development of such a care network in co-operation with the other stakeholders in the sector (Article 107 of the federal hospital law).

In June 2011, ten project proposals to implement the network were approved by the inter-ministerial conference and received a small budget from the federal government of EUR 750 000. One year later, nine more projects were approved. The projects will last for at least three years and are being followed by a team of researchers for evaluation. After evaluation, it is intended that the framework will be implemented all over the country.

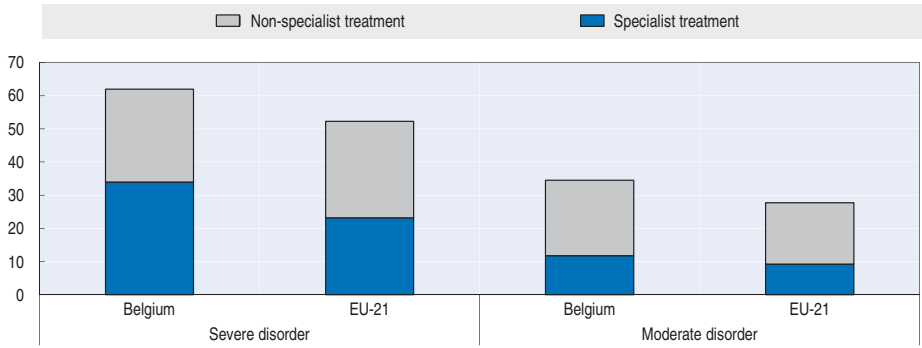
1. *Guide vers de meilleurs soins en santé mentale par la réalisation de circuits de soins et réseaux de soins (www.psy107.be/).*

Identifying and tackling the treatment gap

In spite of the positive effects of treatment, the OECD report *Sick on the Job?* (OECD, 2012) illustrates that under-treatment is potentially very large and that in many cases treatment is inadequate. In Belgium, among people with severe mental disorders, around 60% sought or received treatment in 2010 and this proportion falls to 35% for people with a common mental disorder (Figure 7.2).

Figure 7.2. **Only a minority of people with mental health problems are treated**

Share of all people with mental health problems who received treatment by type of treatment[a] and severity of mental disorder in Belgium and on average over 21 European OECD countries, 2010



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

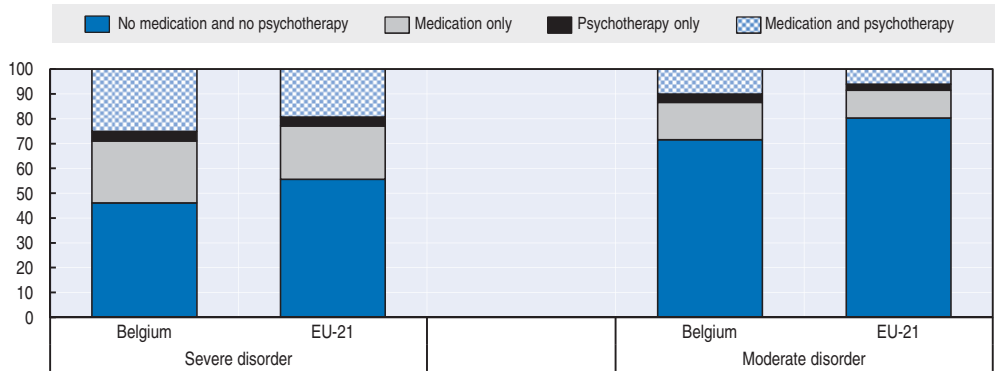
Source: OECD calculations based on Eurobarometer, 2010.

Although slightly higher than the OECD averages of 52% and 28% respectively, these shares are low, even though some people might not need treatment. In addition, of those that were treated for a severe mental

disorder, 46% saw a doctor but receive neither medication nor psychotherapy, 25% received medication but no therapy and 3.8% received therapy but no medication (Figure 7.3).

Figure 7.3. **Only a minority of all patients receive combined medication-therapy treatment**

Share of people in professional treatment[a] who received antidepressant medication and/or psychotherapy, in Belgium and on average over 21 European OECD countries in 2005 by severity of mental disorder



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

Source: OECD calculations based on Eurobarometer, 2005.

Only one in four received both psychotherapy and medication – which is generally regarded as the optimal treatment for most mental disorders (Lethinen *et al.*, 2007). The share is even lower for people with moderate mental disorders. Moreover, psychotropic medication is not always used in the most effective way. Data from the National Institute for Sickness and Invalidity Insurance show that the majority of people use antidepressants for very short periods only, while scientific guidelines recommend treatment of at least six months.[1]

The referral to specialist care is problematic

The lack of adequate treatment, and even treatment overall, is related to the issues of awareness and disclosure, as well as to the problematic referral to specialist care (Dezetter *et al.*, 2012). When seeking treatment, people predominantly consult GPs first. However, medical studies only partially prepare GPs for recognising and treating people with mental disorders (De Coster *et al.*, 2004), and they currently do not have the option to contact a mental health specialist for a short consultation concerning the treatment

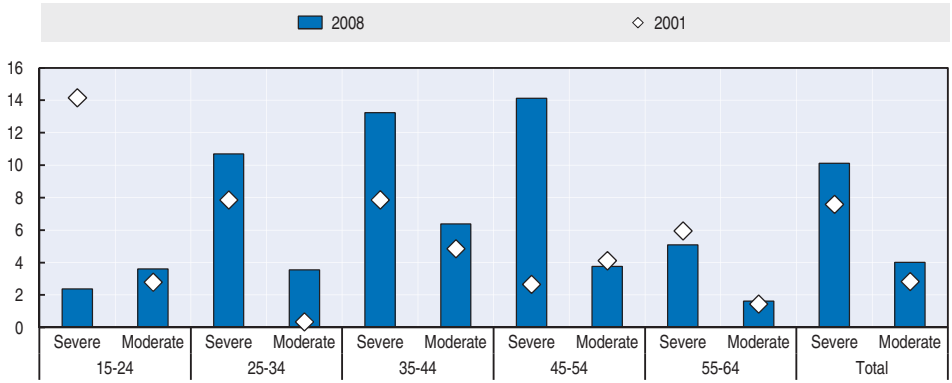
of their patients with mental health problems or to send their patients at short notice to a psychiatrist for a expert advice (Claes *et al.*, 2010).

The referral to specialist care is problematic for a number of reasons. First, the stigma attached to mental disorders restrains people from seeking help from mental-health professionals (Alonso *et al.*, 2009). Second, waiting lists for psychiatrists and other mental health services are long (Vandeurzen, 2010). The average waiting time for the Flemish mental health centres is 40 days – up from 33 days in 2009 – although this differs substantially across municipalities.[2] Only 65% of patients obtain an appointment within a month, while 16% have to wait for more than two months. The average waiting time for a second appointment is another 40 days on average. Also psychiatrists are typically not available in the short term (Claes *et al.*, 2010). Third, while the supply of treatment offered by independent psychotherapists is not so much of a problem in Belgium, the lack of required qualifications for psychotherapists dilutes the quality of the treatments that are available (Claes *et al.*, 2010). Anybody can call themselves a psychotherapist, without the need for a diploma (although many are psychologists or psychiatrists), resulting in a wide variety in quality. Besides references from other users or specialists in the field, there is no way to judge the competence of a psychotherapist and the quality of their treatment.

In addition, the preference for medication over psychotherapy is in part related to the relative costs of the two approaches – with medication generally being cheaper than (sustained) professional therapy – even though data from the Belgian Health Interview Survey show that only a minority of those who need mental health treatment cannot afford it (Figure 7.4). While psychotherapy sessions with a psychiatrist are reimbursed by the National Institute for Sickness and Invalidity Insurance, similar sessions with psychologists or psychotherapists are not covered, to a large extent because of the lack of regulation for psychotherapists. Some of the mutualities offer reimbursement of such sessions to their members through additional insurance schemes, but rules and coverage vary greatly across mutualities and even within branches of mutualities, and these conditions change continuously.[3] In many cases, only psychotherapy for children and adolescents are covered. Some mutualities impose (some) constraints on the choice of the providers of psychotherapy, while others request referral by a general practitioner, centre for mental health, student guidance centre or welfare office.

Figure 7.4. **Only a minority cannot afford mental health treatment**

Share of people living in a household where a member needed mental health treatment in the past 12 months but could not afford it, by mental disorder and age, 2001 and 2008



Source: OECD calculations based on data from the Belgian Health Interview Survey.

Conclusion and recommendations

The mental health sector in Belgium is complex and highly focussed on hospital care for people with severe mental disorders. Close co-operation and co-ordination between the different care providers (primary, secondary and tertiary care) is lacking and waiting lists for treatment are long. At the same time, under-treatment is potentially very large and in many cases treatment is inadequate, As such, the ongoing mental health reform to reorganise the sector towards a more consolidated and continuous care system is highly welcome. While the pace of the reform has been rather slow up till now, all stakeholders (several ministries at federal, regional and community level) now agree on the broad reform lines. The recent involvement in this process of the labour ministries is an opportunity to improve the co-operation and co-ordination with the employment services.

Recommendations

- Introduce a legally protected title for psychotherapists to improve the quality of treatments offered and to promote the accessibility of the sector. This would also facilitate the reimbursement of treatment costs by the mutualities and potentially narrow the treatment gap.
- Extend the continuous care networks throughout Belgium. Oblige hospitals to further reduce the number of psychiatric beds per capita

to the average OECD level and closely co-operate with the mental health centres.

- Involve public employment services, employers, occupational health services and mutualities in the mental health care reform and test different ways of integrating health and employment services.
- Facilitate the referral to specialist services and introduce telephonic contact points where GPs can get advice on mental health problems and adequate treatments.

Notes

1. One in four users of antidepressant takes his or her medication for less than one month (*i.e.* the equivalent of 30 "defined daily doses" or DDD, the assumed average maintenance dose per day for a drug used on its main indication in adults), while barely 28% of the users take medication for more than six months. For antipsychotic medication, more than half of the users take the medication for a month or less. The data are taken from the Pharmanet data collection of the National Institute for Sickness and Invalidity Insurance *(www.riziv.be/drug/fr/statistics-scientific-information/pharmanet/introduction/index.htm)*.
2. Data are obtained from the Flemish Agency for Care and Health (*www.zorg-en-gezondheid.be/*).
3. For a detailed overview of reimbursement rules for psychotherapy sessions with psychologists or psychotherapists across mutualities, see *http://users.myonline.be/allemeesch/KlinPsy/Terugbetaling.htm* (in Dutch).

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Annex A

Trends in expenditure on disability and sickness in Belgium

In percentage of GDP, in percentage of unemployment benefit spending and in percentage of total public social spending

	% GDP		% Unemployment	% Public social spending
	2000	2009	2009	2009
Australia	2.0	1.8	331	10.2
Austria	3.3	2.8	259	9.5
Belgium	1.9	2.2	67	7.3
Canada[a]	0.5	0.5	48	2.5
Chile	0.7	1.2	15 558	9.8
Czech Republic	2.2	2.0	195	9.6
Denmark	2.6	3.4	371	11.3
Estonia	1.2	1.8	162	7.5
Finland	3.0	3.4	215	11.5
France	1.5	1.6	108	5.0
Germany	2.8	2.6	159	9.2
Greece	1.4	1.3	181	5.4
Hungary	1.0	2.0	246	8.2
Iceland	3.1	4.1	247	22.4
Ireland	1.1	2.2	84	9.3
Israel[b]	1.2	1.6	372	9.9
Italy	1.6	1.3	193	4.8
Japan	0.4	0.5	69	2.2
Korea	0.2	0.2	52	2.1
Luxembourg	2.3	2.2	218	9.2
Mexico	0.0	0.0	..	..
Netherlands	4.9	3.8	262	16.4
New Zealand	1.2	1.4	290	6.4
Norway	5.1	5.7	1 352	24.3
Poland	2.7	1.7	828	8.0
Portugal	1.7	1.7	138	6.6
Slovak Republic	1.9	1.5	516	8.1
Slovenia	2.2	1.8	377	7.7
Spain	2.2	2.4	69	9.2
Sweden	4.1	3.4	462	11.3
Switzerland[c]	2.8	2.6	502	14.4
Turkey	0.2	0.3	..	2.7
United Kingdom	2.8	2.9	620	11.9
United States	1.5	1.8	210	9.6
OECD	2.0	2.0	209	9.2

.. : Data not available.

Note: Disability refers to public and private disability pensions; sickness refers to public and private paid sick leave programmes (occupational injury and other sickness daily allowances).

a. Data do not include spending on provincial social assistance payments with a disability designation (which would roughly double the spending figure), nor spending on voluntary private long-term disability plans.

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

c. Data refer to 2008 instead of 2009.

Source: OECD Social Expenditure Database (www.oecd.org/els/social/expenditure).

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