Mental Health and Work

DENMARK

OECD

Mental Health and Work: Denmark

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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 Denmark is one in a series of reports looking at how these policy challenges are being tackled in selected OECD countries, covering issues such as the transition from education to employment, the role of the workplace, the institutions providing employment services for jobseekers, the transition into permanent disability and the capacity of the health system. The other reports look at the situation in Australia, Austria, Belgium, 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.

Work on this review of Denmark 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 Christopher Prinz. Statistical work was provided by Dana Blumin and Maxime Ladaique. Valuable comments were provided by John Martin, Mark Keese and Veerle Miranda. The report also includes comments from a number of Danish authorities, including the Ministries of Employment, of Health, of Social Affairs and Integration and of Children and Education, the Pensions Agency, the Labour Market Authority, the Working Environment Authority, the Confederation of Danish Trade Unions, and the Danish Employers' Confederation.

Table of contents

Figures

Tables

Acronyms and abbreviations

ACC	Acute Crisis Centre
ALMP	Active Labour Market Programme
EPL	Employment Protection Legislation
EWCS	European Working Conditions Survey
GAD	Generalised Anxiety Disorders
GP	General Practitioner
HMIS	Health Management Information System
ICD-10	International Classification of Disease (version 10)
NBH	National Board of Health
MDE	Major Depressive Episode
PPR	Educational Psychological Advisory Service
PWE	Psychosocial Working Environment
RLMA	Regional Labour Market Authority
RTW	Return to Work
SF-12	Mental health profile (based on 12 questions)
SHARE	Survey of Health, Ageing and Retirement in Europe
SUSY	Danish National Health Interview Survey
VET	Vocational education schools
YGC	Municipal Youth Guidance Centres
WEA	Danish Working Environment Authority
WECC	Working Environment Consultancy Company
WHO	World Health Organization

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 substantial productivity losses. Danish policy makers see the need for stronger action to prevent people from dropping out of the labour market due to mental illness and help those with a mental disorder to find sustainable jobs. Denmark is in a good position to tackle the challenges of mental ill-health, as it can build upon a number of system strengths. These include, for example, a good municipal structure for following up on youth at risk as well as for providing employment services to everyone in need of help. It also has an accessible health system that widely reimburses psychological therapies. Nevertheless, change is needed in order to improve the situation significantly. Changes should include a better implementation of existing regulations and more generally a stronger focus on mental health in current health, social and labour market policies and ongoing welfare reforms.

The OECD recommends that Denmark:

- Assure that ongoing social and labour market reforms, such as the reform of the scheme of subsidised flexjobs, will deliver also for people with a mental disorder.
- Minimise school dropout and improve the transition to secondary education and employment for adolescents with a mental illness.
- Tackle mental ill-health in the workplace with a focus on people facing performance problems but not yet taking relevant sick leave.
- Aim to identify widespread mental health problems among clients of municipal job centres, and address these problems with a range of both health and targeted employment interventions.
- Improve work-capacity assessments for disability benefit eligibility including an identification of needs, especially for claimants with a mental disorder, and introduce periodic reassessments.
- Develop employment-oriented mental health care, and experiment with ways to integrate health and employment services.

Assessment and recommendations

Mental ill-health costs the Danish economy around 3.4% of GDP every year through lost productivity, social benefits and healthcare, and poses increasing problems for the well-functioning of social and labour market policies. A few years into the Great Recession, the situation in Denmark is now characterised by a concurrence of high unemployment and high disability. Importantly, the share of mental disorders is very high among both unemployment and disability benefit claimants – at 30% and 45%, respectively – and even higher among people receiving a social assistance or long-term sickness benefit (55% and 70%, respectively). At the same time, people with a mental disorder face a considerable employment disadvantage, with a gap in employment rates of around 15 percentage points and an unemployment rate which is double the overall rate. On top of this, a large share of those who are employed struggle in their jobs, with four in five workers with a mental disorder reporting occasional reduced productivity at work compared with only one in three workers without such disorder.

The Danish system has much potential to tackle the challenges of mental ill-health and work

Policy makers and key stakeholders responsible for implementing social, health, education and labour market policy in Denmark acknowledge the need for action to address mental ill-health challenges. This is reflected in the strong focus on mental health in some of the general system reforms, such as the forthcoming reform of the disability benefit system. Denmark has a number of strengths in its system on which reform can build, including:

- Labour law with relatively strong focus on the psychosocial work environment;
- Competent Youth Guidance Centres which have an overarching role in following young people;
- Municipal job centres which provide employment services to everyone irrespective of labour market distance or benefit status;

- A highly flexible system of subsidised wages (so-called flexjobs);
- A strong focus on remaining work capacity in disability benefit eligibility determination; and
- An accessible public health care system providing services free of charge, including reimbursement of psychological therapy.

However, systems are often under-resourced to tackle mental ill-health effectively; or they have no means to identify and, hence, help those with a mental disorder; or they fail to achieve the desired outcomes for this group. Much more could be done to boost policy effectiveness and implementation and, thereby, improve the labour market inclusion of people with a mental illness and avoid labour market exits caused by mental ill-health.

Assuring that ongoing and planned reforms will deliver

Big reforms are currently in the pipeline which will change the policy co-ordinates of the Danish social and labour market system more broadly. Three of them are particularly important for people with a mental disorder. These reforms have considerable potential because they aim to do away with structural weaknesses that have long been in place and have hindered a real improvement.

- For people under age 40, the disability benefit scheme is going to be replaced by a new rehabilitation model with integrated health, social and employment services (with only few people of this age continuing to be entitled to a permanent disability benefit). In the best case, this model could become a blueprint for disability reform in other countries, but it could also fail largely because of unclear responsibilities and incentives and a lack of effective monitoring.
- The flexjob scheme of subsidised employment is also undergoing far-reaching change including removal of the main structural weaknesses such as the fact that it is far too generous. However, scepticism is indicated because so far the system failed to reduce the number of disability benefit claimants and instead incited people to switch from regular jobs into flexjobs. The impact of the new flexibility of the system (in terms of hours worked and subsidised) and the temporary nature of entitlements remains to be seen.
- A third relevant change is the planned reform of the reimbursement mechanism by which municipalities' social and labour market spending is refunded by the state. The current system which distinguishes by type of intervention or benefit, with increasing complexity, has been criticised for providing incentives for

municipalities to "play" the system. Moving to a new funding mechanism which distinguishes by duration how long the client has been in the system has good potential, especially for people with a mental disorder who tend to be further away, and for longer, from the labour market.

It will be important to monitor and evaluate these reforms very tightly and adjust the schemes quickly should they fail to deliver the desired outcomes. It would also be critical to assess the impact of these reforms for people with a mental disorder, which would partly require more efforts to identify this group of clients in the first place (see below).

Improving transitions to higher education and employment

Denmark has sound school-based policies in place to help youths and adolescents with a diagnosed severe mental disorder which will not necessarily help the large number of pupils with a mild and moderate and typically unidentified mental disorder. The latter group is best helped through strong general school support services, which are also well connected with the health system. The municipal educational-psychological advisory service should play a larger role in this context. The municipal Youth Guidance Centres, on the contrary, have recently been upgraded to help young people move from lower into upper secondary education and the labour market and prevent frequent dropout from upper secondary schools. In view of the high average age of Danish students, in particular in vocational schools, these centres should also help those aged 25-29.

Denmark has reacted very quickly to rising youth unemployment in the course of the Great Recession. Many of the recent labour market measures have good potential to help those with a moderate mental disorder. Denmark is also reacting to the poorly understood structural trend increase in disability benefit claims of young people, most of them claiming with a mental disorder, by replacing disability benefit with a new rehabilitation approach for those under age 40.

Forcefully tackling mental ill-health in the workplace

Negative attitudes towards workers with mental illness persist and will continue to be a barrier to better labour market inclusion and work performance. Policy in Denmark has moved significantly in two ways to address more effectively mental health issues in the workplace: first, in terms of prevention of psychosocial risks at work, through a gradual extension of existing workplace health and safety regulations; secondly, by a steady development of the sickness monitoring process and more

involvement of employers in this process. The remaining problem in both cases is a weak implementation of new legislation.

The area in which Denmark will have to catch up most is in helping the large number of workers ill enough to face major performance problems while at work, but not taking any longer-term sick leave. Working environment consultancy companies contracted by most employers should play an active role in work and workplace accommodation and in securing job retention.

Addressing mental ill-health among clients of municipal job centres

Denmark's one-stop-shop job centres for all jobseekers provide a unique opportunity to service people in the best possible way. However, much more could be done to reap the opportunities this unique setup provides. The mainstreaming approach used by the job centres allows access to all kinds of measures for all types of clients, but clients with complex disadvantages and those with a mental disorder will have great difficulties in benefitting from this "free" access to all services. This is unfortunate in view of the large share of the job centre clientele suffering from mental ill-health. The absence of systematic mental health screening and the sole reliance on caseworkers in this regard implies that some of the main barriers to finding suitable employment will remain unaddressed.

Much is known about what intervention works best for which groups of clients, and even though mental health status is not part of the analysis and data collection in most cases, quite a few inferences can be drawn on what works best and what needs to be done for those with a mental disorder. Key success factors include involving the employer quickly if the client has an employment contract; meeting the caseworker quickly and regularly; investing in low caseloads and psychological training for caseworkers; moving to support that is flexible and adjustable; and providing opportunities for work trials in a real-work setting with continuous contact with the job centre.

Improving assessment for disability benefit eligibility

Disability benefit in Denmark aims to provide a security net for people unable to work even in a subsidised job. Thus defined, very few people should qualify for a disability benefit. In practice, however, the number of new claims is very high, with the majority of people claiming with a mental disorder. Among other things, this is explained by a comparatively high approval rate of new benefit claims and a lack of reassessment, in turn

implying that disability benefit is an accessible permanent payment, also for people whose conditions improve. These aspects should be reconsidered.

Assessment is critical for determining both benefit inflow and benefit outflow. The resource profile used in Denmark to establish disability benefit eligibility is now considered a failure because of its complexity and the lack of guidance on appropriate implementation. Building on the elements of the resource profile and on the findings of national and international research, a new assessment is being tested in the context of a large-scale return-to-work trial, with a focus on seeking early agreed decisions by all involved systems and actors. Initial outcomes of this country-wide trial seem promising. Any revised assessment scheme will have to pay particular attention to the way it affects claimants with a mental disorder.

Developing employment-oriented mental health care

Unmet mental health service needs can only be estimated roughly but the shortage of psychiatric services at all levels of the mental health system is undisputed. More investment in psychiatric service capacity is needed but also in measures to ensure first-line health care providers, especially GPs, are able to fulfil the many roles they have in health service provision for the mentally ill. The connection between general and specialised health care will also have to be improved.

The biggest challenge for mental health care in Denmark is the disconnection between health services (a regional task) and social and employment services (a municipal task). Health care follows aims and principles very different from those followed by the municipal job centres: while the main aim of the latter is to bring people into employment, the former aims to improve the person's health through care and treatment. The Danish mental health care system is only in the early stages of recognising its employment responsibility. Much better integration of health services with social and employment services will be necessary.

Summary of the main OECD recommendations for Denmark

Key policy challenges	Policy recommendations
1. Ongoing reforms in various areas are promising, but experience suggests that desired outcomes have not always been achieved	• Implement disability benefit reform for the under 40s rigorously with clear roles and incentives for the key actors to ensure that the new rehabilitation model delivers. • Implement flexjob reform rigorously to do away with the many weaknesses of a system which has very good potential. • Modify the reimbursement mechanism for municipal employment and benefit spending as planned (based on the client's duration in the system) and evaluate the result.
2. School supports for common mental disorders are ineffectual and dropout from vocational schools is too high	• Provide sufficient resources for common mental disorders and make better use of municipal educational-psychological advisory services. • Further improve the effectiveness of the Youth Guidance Centres responsible for the transition to upper-secondary school and the follow-up of dropouts up to age 25, and extend their role to those aged 25-29. • Help dropouts with a mental disorder to access the labour market through demand and supply measures; enforce mandatory enrolment in an education programme.
3. Mental health risks and problems in the workplace are not addressed forcefully enough	• Inspect psychosocial workplace risks and employer action rigorously; shift resources of the Working Environment Authority to be able to focus better on those risks. • Strengthen the role of working environment consultancy companies as workplace conflict managers and facilitators of work and workplace accommodation. • Tackle sickness absence by monitoring employer action and involving job centres earlier than after eight weeks, if necessary.

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

Key policy challenges	Policy recommendations
4. Mainstreaming of mental health issues among municipal job centre clients is not bearing fruit	• Develop better means to identify mental health problems which are a key barrier to employment for a large share of job centre clients. • Make clients with a mental disorder a new target group for job centres, with regional and national targets, and pay particular attention to clients moving from unemployment to sickness benefit. • Invest resources in low caseloads for clients with a mental disorder and psychological training for caseworkers.
5. The assessment approach used by the Danish disability benefit system is not identifying remaining work capacity in the intended way	• Increase the effectiveness of the resource profile used to determine benefit eligibility, taking into account the lessons from the large-scale return-to-work trial. • Extend the planned rehabilitation model for the under 40s, with integrated employment, social and health services, to all age groups. • Reassess both new and existing disability benefit entitlements regularly; very few people should have a permanent benefit entitlement.
6. Mental health care supply does not match demand, and the link with employment is underdeveloped	• Increase the capacity to deliver effective mental health care, by raising the number of specialists and authorised psychologists and improving mental-health knowledge of GPs. • Promote shared care models to facilitate a better connection between primary and specialist mental health care. • Test different ways of integrating health and employment services.

Chapter 1

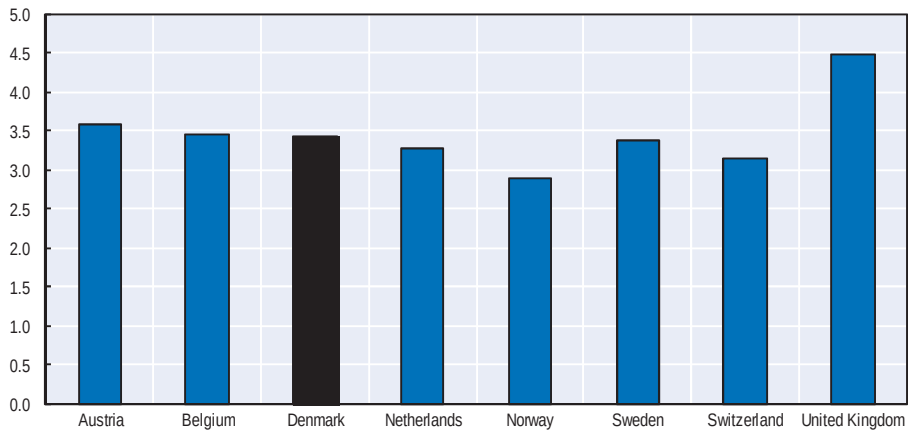
Mental health and work challenges in Denmark

This chapter discusses the current labour market performance of people with a mental disorder in Denmark compared to other countries in terms of their employment and unemployment situation, with a view on sickness absence and reduced productivity of those working. Building on the findings in the 2011 OECD report "Sick on the Job?" *it highlights the key challenges ahead, such as the high share of people on different social benefits who suffer from a mental health condition. The chapter also provides a description of the Danish benefit system and Danish employment policy and discusses the role of different levels of government.*

Mental ill-health poses enormous challenges for the well-functioning of labour market and social policies in Denmark as much as in other OECD countries. These challenges have not been addressed adequately so far, reflecting widespread stigma and taboos. The total estimated costs of mental ill-health for the Danish economy are large at 3.4% of GDP, which puts Denmark near the middle of the cost-range in the group of eight OECD countries shown in Figure 1.1.[1] Indirect costs in the form of lost employment and reduced performance and productivity 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 the economy.

Figure 1.1. **Mental disorders are very costly to 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: definitions and objectives

The OECD report *Sick on the Job? Myths and Realities about Mental and Work* concluded that a three-fold shift in policy is required to respond effectively to the challenges of ensuring greater labour market inclusion of people with mental illness (OECD, 2012a). More attention needs to be given to *i)* mild and moderate mental disorders as opposed to severe disorders;

ii) disorders concerning the employed and unemployed; and *iii)* preventing instead of reacting to problems arising from mental health issues.

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

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

One important general challenge for policy makers is the very high rate of non-awareness, non-disclosure and non-identification of mental disorders – which is directly linked with the stigma attached to mental illness. It is also not clear that better and earlier identification would improve outcomes in all cases or might instead contribute to stereotyping and stigmatisation. This implies that reaching out to people with a mental disorder is more important than merely labelling them as suffering from a mental illness and policies that avoid labelling might sometimes work best.

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

This report examines how policies and institutions in Denmark are addressing the challenge of ensuring that mental ill-health does not mean exclusion from employment and that work itself contributes to better mental health. A number of specific issues are addressed. How are the critical institutions and stakeholders – schools, employers, employment services, social services and psychiatric services – organised and resourced to identify people with a mental disorder? What is done and how quickly when a problem has been identified, and what is done more generally without stigmatising those in need? How are the different actors co-operating and how are different

services integrated to ensure people get the right services quickly to access the labour market, remain in their job or return to employment?

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

Administrative clinical data and data on disability benefit recipients generally include a classification code on the diagnosis of a patient or benefit recipient, based on ICD-10, and hence the existence of a mental disorder can be identified. This is also the case in Denmark. However, administrative data do not include detailed information on an individual's social and economic status and they cover only a fraction of all people with a mental disorder.

On the contrary, survey data can provide a rich source of information on socio-economic variables, but in most cases only include *subjective* information on the mental health status of the surveyed population. Nevertheless, the existence of a mental disorder can be measured in such surveys through a mental health instrument, which consists of a set of questions on aspects such as irritability, nervousness, sleeplessness, hopelessness, happiness, worthlessness, and the like, with higher values indicating poorer mental health. For the purposes of the OECD review on *Mental Health and Work*, drawing on consistent findings from epidemiological research across OECD countries, the 20% of the population with the highest values according to the instrument used in each country's survey is classified as having a mental disorder in a clinical sense, with those 5% with the highest value categorised as "severe" and the remaining 15% as "mild and moderate" or "common" mental disorder.

This methodology allows comparisons across different mental health instruments used in different surveys and countries. See *www.oecd.org/els/disability* and OECD (2012a) for a more detailed description and justification of this approach and its possible implications. Importantly the aim here is to measure and compare the social and labour market outcomes of people with a mental disorder, not the prevalence of mental disorders as such. For this report on Denmark, data from four different population surveys are used:

1. The *Danish National Health Interview Survey* (SUSY) for 1994, 2000 and 2005 (the 2010 round is not used because of several changes in definitions) where the mental disorder variable is based on the mental health and vitality items of the SF-12 scale, developed to measure quality of life and health.
2. The *Eurobarometer* for 2005 and 2010 where 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 *Survey of Health, Ageing and Retirement in Europe* (SHARE) for 2004 and 2006 where the mental disorder variable is based on the EURO-D depression scale, which is built on 12 items: depression, pessimism, suicidal feelings, guilt, sleep, interest, irritability, appetite, fatigue, concentration, enjoyment, and tearfulness.
4. The *European Working Conditions Survey* (EWCS) for 2010 where the mental disorder variable is based on a set of five items: feeling cheerful; feeling calm; feeling active; waking up fresh and rested; and life fulfilment.

The structure of the report is as follows. This first chapter sets the scene by looking at key labour market outcomes for people with a mental disorder, in Denmark compared with other countries, and describing the main systems catering for people with mental illness and the responsibility of different government levels. This is followed by chapters which look consecutively at the policy challenges Denmark is facing at a number of critical stages of a person's lifecycle, including: the period before a young person enters the job market; time spent at work and interventions happening under the responsibility of the employer; and when a person is at risk of leaving the labour market and entering the benefit system or is seeking to return to work. The last chapter examines the role and contribution of the health system in dealing with mental ill-health at each of these stages of the lifecycle. Each chapter concludes with specific policy recommendations.

The outcomes: where Denmark stands

Denmark was hit hard by the recent economic downturn. The country endured an unprecedented drop in production (output fell by 8% from peak to trough) and in 2011, GDP was still below its 2006 level (OECD, 2012b). Economic contraction translated into significant jobs losses. Unemployment rates have reached a 20-year peak, with a rate of 7.7% in 2011, and they more than doubled for young people. Long-term unemployment also increased to around one quarter. The situation has stabilised lately but it has not improved yet. The employment-population ratio also fell but remains high by international standards for all age groups (Table 1.1).

Table 1.1. **Denmark's labour market was hit hard by the Great Recession**

Employment and unemployment indicators for selected OECD countries, 2000 and 2011

	Employment population ratio				Unemployment rate				Long term unemployment		Temporary work		Part-time work	
	15-64		15-24		15-64		15-24							
	2000	2011	2000	2011	2000	2011	2000	2011	2000	2011	2000	2011	2000	2011
Australia	69.3	72.7	62.1	60.7	6.4	5.2	12.1	11.3	28.3	18.9	4.8	5.2	23.7	24.7
Austria	68.3	72.1	52.8	54.9	3.5	4.2	5.1	8.3	25.8	25.9	7.9	9.6	12.2	18.9
Belgium	60.9	61.9	30.3	26.0	6.6	7.2	15.2	18.7	56.3	48.3	9.0	9.0	19.0	18.8
Denmark	**76.4**	**73.1**	**67.1**	**57.5**	**4.5**	**7.7**	**6.7**	**14.2**	**20.0**	**24.4**	**10.2**	**8.8**	**16.1**	**19.2**
Netherlands	72.1	74.9	66.5	63.6	3.1	4.4	6.1	7.7	43.5	33.6	14.0	18.4	32.1	37.2
Norway	77.9	75.3	58.1	51.4	3.5	3.3	10.2	8.6	5.3	11.6	9.3	7.9	20.2	20.0
Sweden	74.3	74.1	46.7	40.4	5.9	7.6	11.7	22.9	26.4	17.2	15.2	16.4	14.0	13.8
Switzerland	78.4	79.3	65.1	62.9	2.7	4.2	4.9	7.7	29.0	38.8	11.5	12.9	24.4	25.9
United Kingdom	72.2	70.4	61.5	50.1	5.5	8.0	11.7	20.0	28.0	33.4	6.8	6.2	23.0	24.6
United States	74.1	66.6	59.7	45.5	4.0	9.1	9.3	17.3	6.0	31.3	4.0	4.2	12.6	12.6
OECD	65.4	64.8	45.5	39.5	6.3	8.2	12.1	16.2	30.8	33.6	11.3	12.0	11.9	16.5

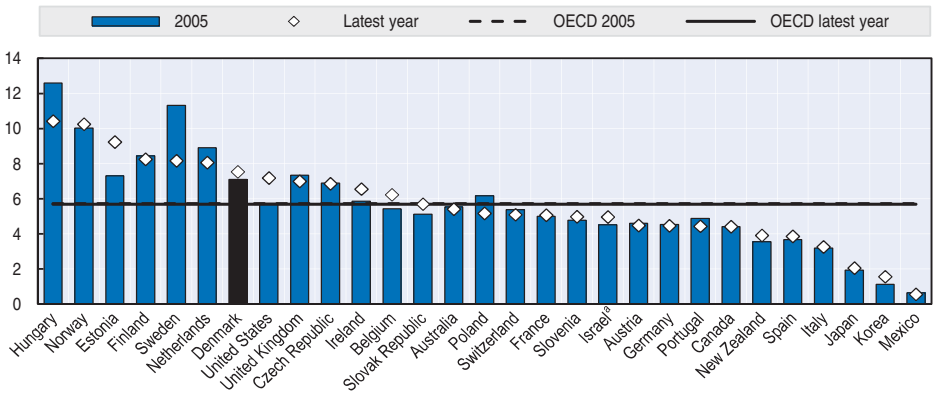
Note: Long-term unemployment data for the Netherlands refer to 1999 instead of 2000, part-time employment data for Australia to 2001 instead of 2000 and for temporary work, to 2001 and 2006 for Australia and to 2001 and 2005 for the United States.

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

At the same time, Denmark is among those OECD countries with a very high disability benefit caseload (Figure 1.2), and more generally with large numbers receiving health-related benefits of different kinds: high and stable numbers on disability benefit, high numbers on long-term sickness benefit, and increasing numbers on highly subsidised flexjobs and a special benefit (the so-called waiting allowance) for people waiting to be placed into such jobs (Figure 1.3). This implies that the situation today is one of high (largely cyclical) unemployment *and* high (structural) health-related inactivity. There is, however, a risk that the high rate of unemployment will push the disability benefit issue to the back of the reform agenda. Policy makers will have to resist this.

Figure 1.2. **The disability benefit caseload is comparatively high in Denmark**

Recipients of disability benefits as a proportion of the population aged 20-64, 2005 and 2010 (or latest year available)



Note: OECD is an unweighted average of the countries shown.

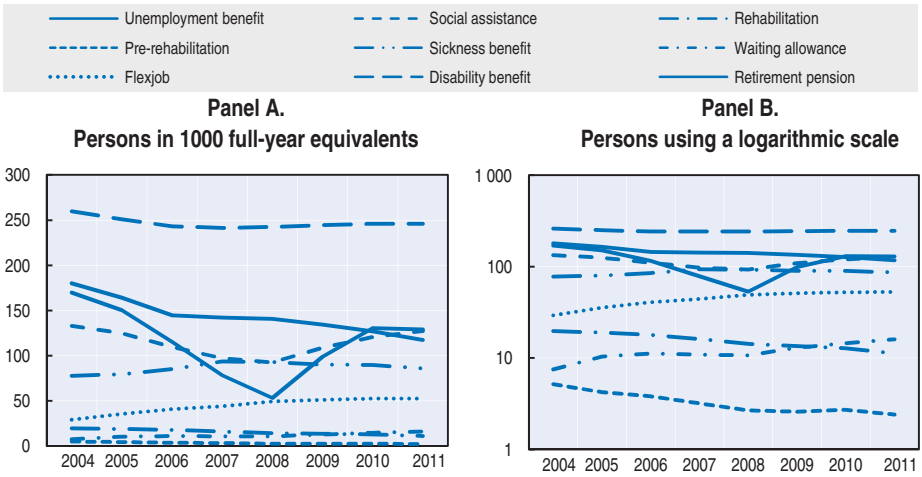
a. Information on data for Israel: http://dx.doi.org/10.1787/888932315602.

Source: OECD questionnaire on mental health.

How is the high rate of disability benefit receipt in Denmark linked to mental ill-health? First, across the OECD today a very large share of all new disability benefit claims is by people with a mental disorder; in Denmark, one of the "vanguard" countries in this regard, almost every second claim is now coming from this group (Figure 1.4). Importantly, those claimants tend to be further away from the labour market and more likely than others to access disability benefits after periods of long and repeated unemployment. OECD (2012a) concluded that this shift in the structure of new disability claims towards mental disorders is partly the consequence of a better awareness of such disorders, especially among people with a co-morbid somatic disorder, and the often false interpretation that such disorders would cause high and permanent work incapacity.

Figure 1.3. **The number of people receiving health-related benefits has changed very little in the past few years**

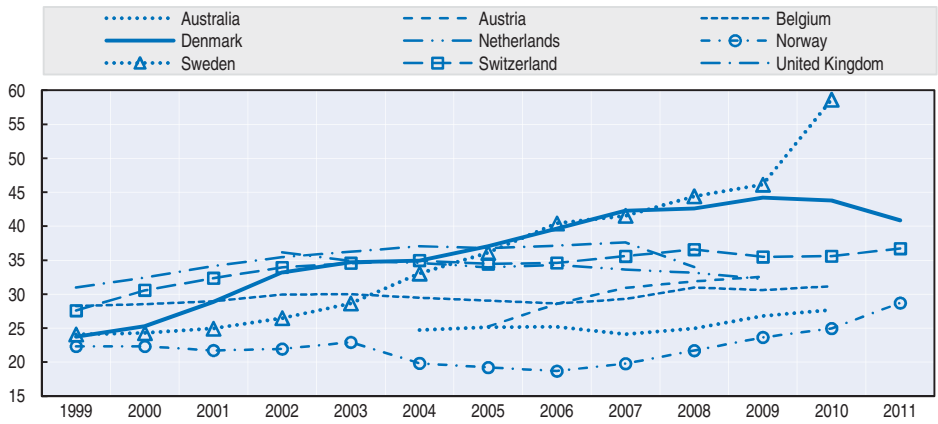
Recipients of various different working-age benefits in Denmark, 2004-11



Source: OECD calculations based on the Jobindsats Database.

Figure 1.4. **Disability benefit claims with a mental disorder are increasing**

New disability benefit claims with a mental disorder in % of all new claims, 1999-2011



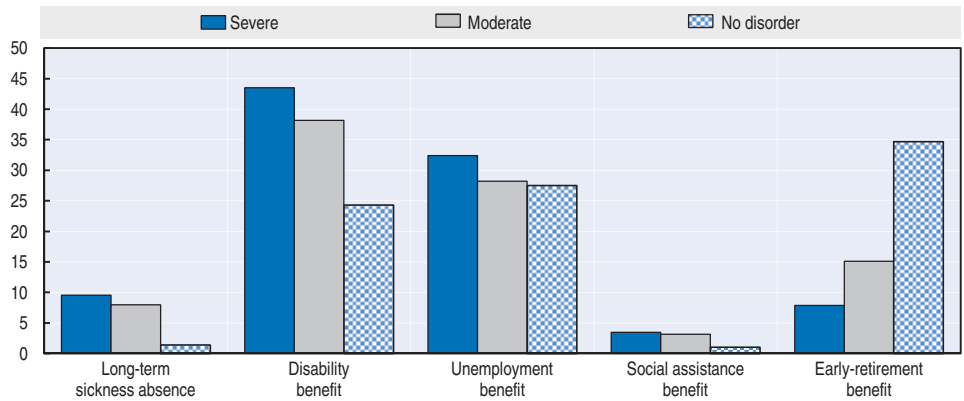
Note: Data for Norway do not include the temporary disability benefit. Belgium, the Netherlands and Sweden include mental retardation, organic and unspecified disorders which account for 13.4% of all mental-disorder inflows on average in countries where data allow identification of these subgroups.

Source: OECD questionnaire on mental health.

Secondly, there is a strong link between mental ill-health and the benefit system in so far as people with a mental disorder receive a range of different working-age benefits. Figure 1.5, based on Danish Health Interview Survey data for 2005,[3] suggests of all those with a severe mental disorder who receive a benefit, some 43% receive a disability benefit and some 33% an unemployment benefit (the corresponding figures are 5 percentage points lower for those with a common mental disorder). People with no mental disorder receive early retirement benefits much more often. The 2005 data also imply that, taken as a whole, people with a mental disorder (either severe or common) are almost twice as likely to receive some working-age benefit compared with people with no mental disorder.

Figure 1.5. **People with a mental disorder receive various working-age benefits**

Proportion of different working-age benefits for people who receive a benefit, by mental health status, 2005



Source: Danish Health Interview Survey (SUSY).

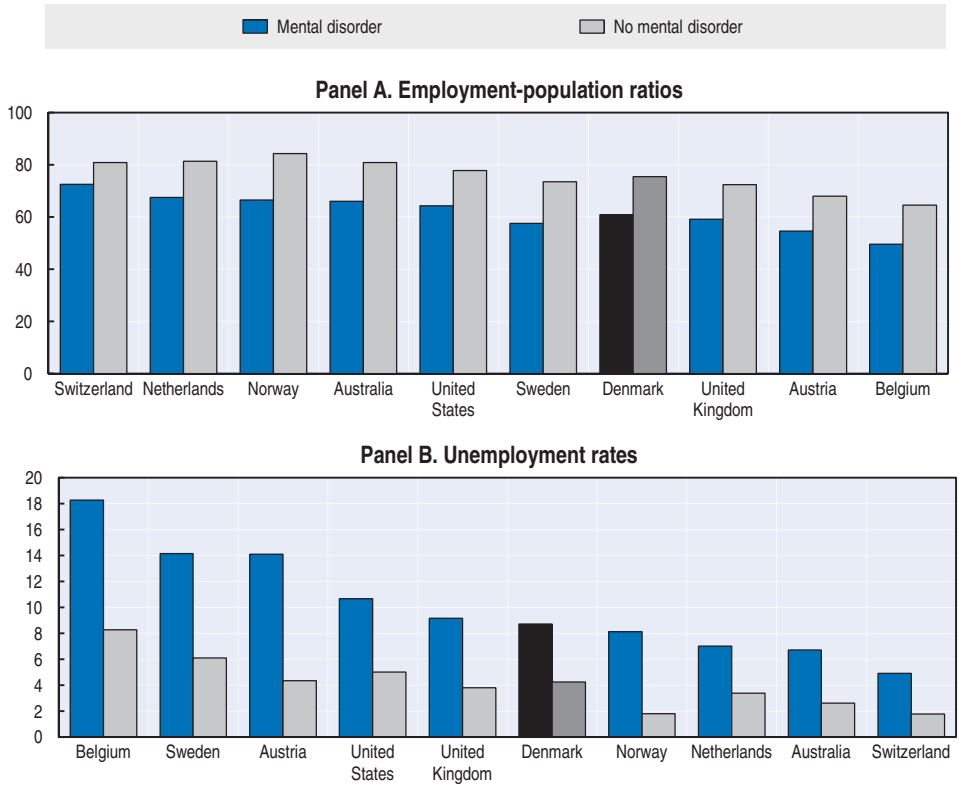
Consequently, many people with a mental disorder are unemployed. Across a range of OECD countries including Denmark, the unemployment rate of people with a mental disorder is consistently two to three times higher than for those with no such disorder – suggesting that many more of them would like to work (Figure 1.6, Panel B). The unemployment gap is related to the fact that people with a mental disorder are more likely both to be dismissed involuntarily and to quit their job voluntarily (OECD, 2012a).

That said, the employment rate of people with a mental disorder (which is a large group of about one-fifth of the population) is relatively high: around 60% in Denmark and closer to 65-70% in some high-employment countries, implying an employment gap with regard to people without a mental disorder in the order of 15 percentage points (Figure 1.6, Panel A).

Added to this, in Denmark but also in most other countries employment rates have increased less in the "past" ten years (1994-2005; *i.e.* before the jobs crisis) for people with a mental disorder than for those without and, similarly, unemployment rates have fallen less (OECD, 2012a; no data available as yet for years after the recent economic downturn).

Figure 1.6. **People with a mental disorder face considerable labour market disadvantage**

Employment and unemployment rates for people with and without a mental disorder, late 2000s

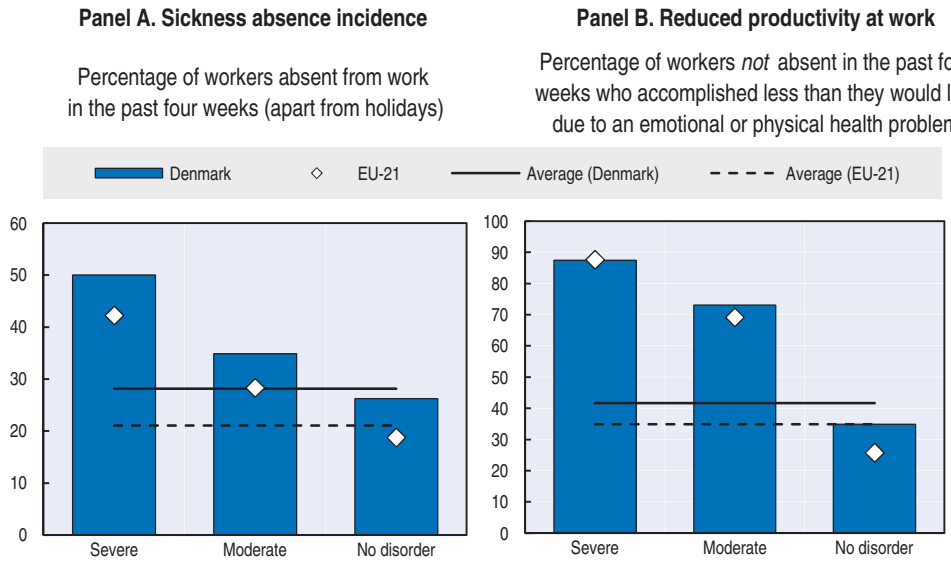


Source: OECD calculations based on national health surveys. Australia: National Health Survey 2007/08; Austria: Health Interview Survey 2006/07; Belgium: Health Interview Survey 2008; Denmark: National Health Interview Survey 2005; Netherlands: POLS Health Survey 2007/09; Norway: Level of Living and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

With so many people with a mental disorder in work, a main question is how they are doing at work. As Figure 1.7 shows, this group is facing major problems on their job. People with a mental disorder take more sick leaves

and, more critically, report performance problems while at work far more frequently. Denmark is no different in this regard from other OECD countries, with around 90% and 70% of those with a severe and moderate mental disorder, respectively, reporting performance problems, compared with 30% of their peers without a mental disorder (Panel B). On the contrary, it appears that sickness absence is systematically higher in Denmark than in the EU average across all three groups (Panel A).

Figure 1.7. **Workers with a mental disorder report major problems on their job**



Source: OECD calculations based on Eurobarometer 2010.

The employment disadvantage also translates into a quite considerable income disadvantage. The poverty risk for people with a mental disorder reaches 20-30% in many OECD countries including Denmark. The low-income gap is larger in Denmark than in many other OECD countries, with the poverty risk being almost twice as high as for people without a mental disorder (Figure 1.8).

In conclusion, the biggest and in many ways intertwined labour market challenges for Denmark include:

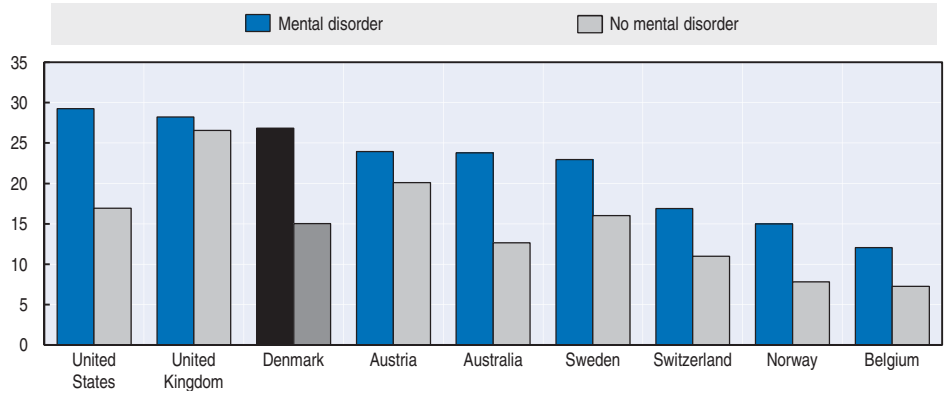
- The concurrence of high unemployment and high disability benefit receipt.
- The high frequency of mental disorders among those on these benefits.

- The employment disadvantage of those with a mental disorder.
- The on-the-job performance problems of people with a mental disorder who are employed.

How these challenges are being addressed by Danish policies and institutions is the focus of this report, following some basic description of relevant systems and institutions in the next section of this chapter. It should be noted that no hard facts are available yet on the impact of the recent economic downturn and the resulting jobs crisis on, first, the mental health status of the working and unemployed population and, secondly, the labour market chances of those with a mental disorder.

Figure 1.8. **Having a mental disorder is a major risk factor for low income**

Percentage of people with household-equivalised income below 60% of median income of the working-age population, latest available year



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

The context: systems, institutions and governments

The Danish benefit system

Labour market policy making in Denmark needs to be seen against the backdrop of its well-known *flexicurity* approach, which is characterised by a combination of three pillars: moderate employment or job protection; high and accessible unemployment benefits; and a strong focus on active labour market programmes. The ease of hiring and firing in Denmark relative to many other OECD countries means that people with a mild or moderate mental disorder are likely to oscillate more frequently than less

disadvantaged workers between employment and unemployment. They may therefore have been particularly vulnerable to job loss following the 2008 global economic and financial crisis as unemployment rose more steeply in Denmark than in many other OECD countries.

Beginning with the previous government (acting until mid-2011) and as continued by the new government, a number of steps are being taken to reform Denmark's flexicurity system. In mid-2012 the duration of unemployment benefit payments was reduced from four years to two years, thereby reducing significantly the generosity of the unemployment benefit system. After two years, the unemployed will be moved onto means-tested social assistance payments. Moreover, further measures are being introduced to activate people on health-related benefits – by attempts to reform more comprehensively both the disability benefit system and the scheme of flexjobs (subsidised jobs for those with a reduced work capacity).

The Danish benefit system has four pillars (Box 1.2): two largely unemployment-related schemes, unemployment insurance benefit and social assistance; and two *main* health-related schemes, sickness benefit and disability benefit (the latter being the most "important" of all benefits when measured in full-year-equivalent recipients; Figure 1.3). In addition there are four *smaller* health-related schemes: rehabilitation benefit, aimed at re-establishing the person's work capacity; pre-rehabilitation benefit to prepare a person for rehabilitation; flexjob benefit, a wage subsidy for those with reduced work capacity; and waiting allowance, a special benefit for those waiting to be placed in a subsidised flexjob.

The other two flexicurity pillars are also well documented. First, the OECD index of employment protection legislation (EPL) suggests that Denmark is among those countries with the least strict EPL, with much lesser protection than its Nordic neighbours especially in relation to individual dismissal of permanent workers (Venn, 2009). Secondly, Denmark is among the countries with the highest income-replacement rates for those who are unemployed, for both the shorter-term and the longer-term unemployed (OECD Benefits and Wages Indicators). The recent cut in the unemployment benefit payment duration from four years to two years will have a significant impact in reducing generosity for singles but not for couples and not those with children more generally.

Box 1.2. **Characteristics of selected Danish benefit schemes**

Unemployment insurance is a voluntary system, requiring membership in an unemployment insurance fund and paying membership fees for at least 52 weeks in the past three years. Currently, only around three in four of the labour force (both employees and self-employed) are insured – this share being lowest and falling fastest recently among younger workers. To re-qualify for benefit, 26 weeks must be spent in paid employment within a three-year period. Eligibility requires to register as a jobseeker with the municipal job centre and to be available and actively looking for work. Activation requirements include weekly confirmation (to the fund) of still being unemployed and available for the labour market and regular interviews with the job centre. Unemployment benefit is paid for two within six years (previously four within six years), with a three-week waiting period in case of voluntary job quit. Payment amounts to 90% of previous earnings but within a narrow minimum and maximum; the latter is worth a bit over 50% of the average wage and the minimum is about 82% of the maximum benefit.

Social assistance ("cash benefit") is a tax-financed benefit of last resort for people who experience a "social risk event" such as unemployment. For people who are ready for the labour market, job search is a prerequisite for eligibility, while other groups have to satisfy other conditions such as treatment and/or activation. Payment rates which depend on age (those under 25 years receive less than those 25 years and older) correspond to roughly 60% and 80% respectively of the maximum unemployment insurance benefit for a single person with and without dependent children (payment rates are calculated for the individual, *i.e.* a married couple can get twice this amount).

Sickness benefit is tax-financed and covers the entire active population with only minor eligibility requirements, including people who receive unemployment benefit or hold a flexjob. Benefits are payable for up to one year in 18 months, with occasional extension by up to six months. Payments are earnings-related, with the maximum payment being equal to the maximum unemployment benefit. Via collective agreements, however, most employees receive a full-wage payment for a considerable period, typically several weeks for blue-collar workers and even up to one year for white-collar workers. Payment of a partial sickness benefit is possible and more frequent recently.

Disability benefit is tax-financed and residence-based. Benefits are permanent flat-rate payments corresponding to almost 70% of net earnings on average, with the full benefit rate for a single person with 40 years of residence being worth 90% of net earnings (with a pro-rata reduction with less than 40 years of residence). Benefit eligibility requires that the person is unable to work in a subsidised flexjob, as determined by a resource profile based on the person's health but also many other life domains. There is no partial disability benefit (the earlier existing graduation by degree of capacity was abolished in 2003) but payments can be accumulated with earnings in a rather generous way.

In conclusion, the net replacement rate on disability benefit is much more generous than on the other main benefits, providing a strong financial incentive (and no activation threat) to get on a disability benefit. Rehab and pre-rehab benefits and waiting allowance provide similarly high payment rates, and flexjob subsidies can be even higher than this.

The responsibilities of different government levels

The key role of the Danish municipalities

Denmark has three rather independent government levels all involved in social, health and labour market policy making and policy implementation: the municipalities, the regions and the state – with the guiding principle in determining responsibility being to provide services at the lowest possible level. Each of the three government levels has different roles, with a range of regulations to control actions and provide incentives to implement policies as intended.

Social and labour market policy is predominantly in the hands of the 98 municipalities, the average size of which has changed recently as a consequence of local government reform (Box 1.3). Municipalities deliver policies through several service units: the job centre, which is responsible for all employment matters and services for all clients, and different benefit units. This setup opens a lot of possibilities for co-ordinated one-stop-shop actions even though benefit units can be quite isolated from the job centre and social and employment services are also split up. The full responsibility of the job centre for all clients irrespective of their benefit status and labour market distance implies that all jobseekers with a mental disorder have a chance to be treated equally. Moreover, the separation of benefit units from employment services is a simple way to avoid pressure on the caseworker while at the same time providing legal security to benefit claimants.

Box 1.3. **Local government reform in 2007**

With a big administrative reform in 2007, the map of Denmark was changed. The number of municipalities was reduced from 271 to 98 in order to create units big enough to manage the varied comprehensive service demands and policy challenges: a legal minimum population size of 20 000 per municipality was set (although in reality a few municipalities are smaller than this); with an average size of 55 000 the Danish municipalities are now much larger than those in other OECD countries. At the same time, the previously existing 15 counties were replaced by five regions, each with a population between 0.6 and 1.6 million, with health care as their main responsibility. Together with this organisational reform, responsibilities of the three levels were also changed in various ways. Overall, today about 48% of total public spending is in the hands of the municipalities, about 43% under the state and the remaining 9% under the new regions (Ministry of the Interior and Health, 2007).

The National Labour Market Authority has responsibility for national labour market policy, in the name of the Ministry of Employment which is setting annual goals.[4] It is also responsible for monitoring of the municipal job centres. This is done through benchmarking against a set of indicators;

the collection of better data; and increasing transparency *e.g.* by way of a regular newsletter which publishes information on the poorest performers. The national government tries to steer municipal responsibility through an elaborate financial reimbursement mechanism: different municipal actions are reimbursed by central government funds at different rates (see Chapter 4 for a more detailed discussion).

Municipalities are also responsible for compulsory education (both primary and lower-secondary schools) including special education for school-age children. Upper-secondary education, adult education and universities, on the contrary, are under state responsibility.

The role of the new Danish regions

The new regions established in 2007 have one main responsibility: health care. This includes hospitals, psychiatric services, and health insurance, *i.e.* general practitioners (GPs), specialists and the reimbursement for medication. However, municipalities also have health responsibilities (and more than prior to local government reform), comprising prevention, rehabilitation outside of hospitals, home care and treatment of substance abuse as well as school health services.

This structure creates new challenges for all aspects involving health and municipal affairs – or, for that matter, for co-ordinating mental health care and treatment (a regional responsibility) with rehabilitation, employment services and job placement (a municipal responsibility). In order to support the new structure, a new health management information system (HMIS) was developed centrally and made available to all municipalities and regions. The system disseminates detailed data on citizens' use of health services.

Regional funding is largely through block grants from the state (about 75% of total revenue of the regions for health care). However, there are two additional components aimed at steering regional and municipal actions: an activity-related subsidy by the state (about 5% of revenue) to encourage the regions to increase the activity level at the hospitals; and an activity-related contribution by the municipalities (about 20% of revenue) depending on their citizens' use of the regional health care system.

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 most mood and anxiety disorders.

3. Data of this type are only available for the year 2005 (the 2010 round of the Danish Health Interview Survey has seen too many changes in definitions to be exploited for this report). Today, in the midst of a job crisis, more people would be found on unemployment and social assistance benefit; and with the reduction of the unemployment benefit payment period, another shift from unemployment to social assistance benefit is forthcoming.

4. The employment goals for 2010, by way of example, were as follows: *i)* to minimise the number of people unemployed continuously for more than three months; *ii)* to reduce the number of people on sickness benefit for more than 26 weeks compared with the previous year; and *iii)* to minimise the number of young unemployed under age 30 who receive social security benefits.

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Chapter 2

Young Danes and their transition into the labour market

This chapter assesses the capacity of the Danish system to help vulnerable youth with common mental disorders enter the labour market. It first discusses strategies to prevent mental health problems in schools and the effectiveness of school services in dealing with mental disorders. Then the chapter reviews policies directed at identifying problems among early school leavers who are at a greater risk of developing a mental disorder. It also examines the effectiveness of employment programmes to boost labour demand for vulnerable youth and addresses the problem of early labour market exit through disability benefit.

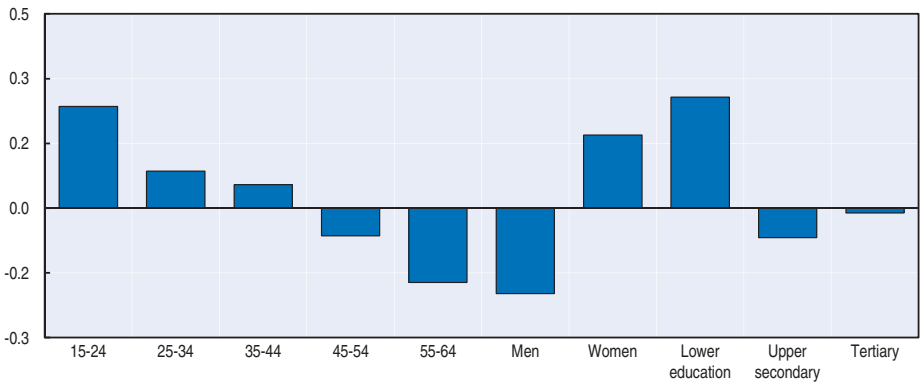
Mental disorders often begin very early in life. The median age at onset across all types of mental illnesses is about 14 and around 11, for example, for anxiety disorders (OECD, 2012). Early mental ill-health can have a significant negative impact on educational and, consequently, employment outcomes. Thus, it is critical to support vulnerable pupils with mental health problems early on in completing their education and making a successful transition into the labour market, while preventing them from slipping into inactivity and permanent dependence on public benefits. Denmark has many good practices in place to tackle these issues. These and some remaining challenges are discussed in the following.

Childhood experiences are critical

On the whole, young adults in Denmark report mental ill-health more often than those aged 45 and over, women more often than men and those with poor education much more often than those with higher education (Figure 2.1). The age gradient suggests that some adolescent mental illness is restored over time or successfully treated or people accept and learn to live with their illness.

Figure 2.1. **The prevalence of a mental disorder is highest among young adults**

People with a mental disorder by age, gender and educational attainment, relative to the overall prevalence in the working-age population, 2005

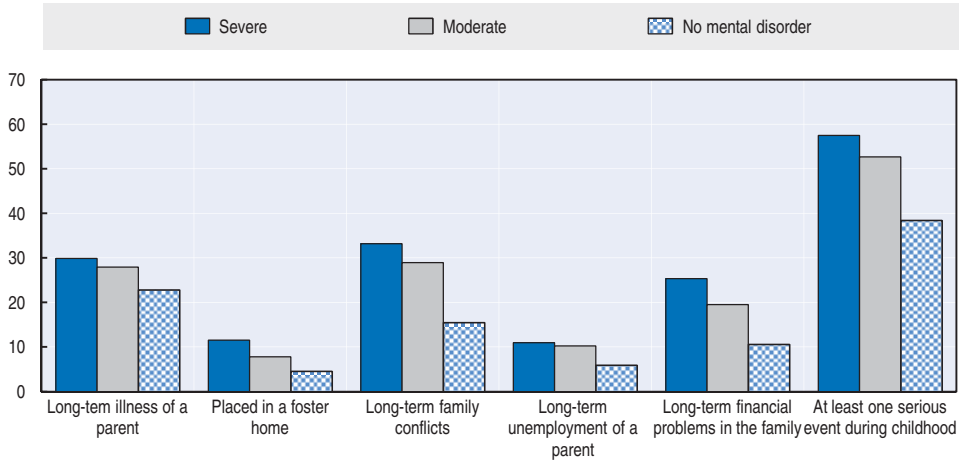


Source: Danish Health Interview Survey (SUSY) 2005.

Childhood is a very critical time for the development of a mental disorder. Danish data for 2005 show that those suffering from a mental disorder systematically have been more likely to have experienced at least one serious event during their childhood, such as long-term illness or unemployment of a parent, long-term family conflicts or financial problems in the family (Figure 2.2).

Figure 2.2. **Childhood experiences matter for mental ill-health later in life**

Share of persons who experienced various serious childhood events, by severity of mental disorder as an adult, 2005



Source: Danish Health Interview Survey (SUSY) 2005.

Such life events cannot be prevented but it is crucial to offer support quickly to those who need it to cope with them. This raises questions as to when and how to identify the need for support and the type of support to be provided – while at the same time avoiding labelling of children as sick. Denmark has chosen a middle path on this issue. There is no specific and systematic mental health screening of children. However, both in early childhood and in school age there are repeated general preventive health examinations by general practitioners and specially trained nurses. These would most likely detect severe mental health problems which would then be taken care of by child and adolescent psychiatric care, predominantly in the hospital sector.

Every child with an identified and diagnosed disability, including those arising from a detected (hence more severe) mental disorder, is entitled to special support in line with special needs provided that the development and learning outcome would be affected without such support.[1] The aim of this support is to ensure that the child will progress to secondary and higher education. In practice, however, children with a mental disorder are unlikely to benefit from such support: this group is a small minority in the group of pupils getting support (predominantly this support goes to children with physical and intellectual disabilities).

There is also a right to education in the hospital for inpatients of school age, with efforts being made to facilitate their return to their regular school or class. For example, this occurs frequently for youth with eating disorders.

Providing a supportive school environment

The age and education disparity in the prevalence of mental ill-health suggest that the school[2] is a critical player in providing services to the large group of young people with mild and moderate mental disorders in particular – disorders which are in most cases hidden, unidentified and undiagnosed.

In Denmark, municipalities are responsible for youth and adolescents with a common mental disorder and for the promotion of good mental health at schools. School principals and school boards have to provide an educational environment conducive to children's health. Class teachers have to monitor the well-being of pupils and seek support if needed. Class teachers and school principals would also be the persons to contact for requests for assistance *e.g.* in the case of bullying.

While teacher training includes some courses on how to identify special educational problems, this does not cover in a systematic way the situation of pupils who have problems with their behaviour, social contacts and general well-being – all of which are possible early signs of a mental disorder.

Teachers can seek help from the educational-psychological advisory service (PPR) of the municipality. In these cases, the PPR's school psychologists will make an assessment of the child's special needs. However, in practice the role of the PPR is mostly to screen and register those entitled to comprehensive special supports and, thus, until now those with a common mental disorder are unlikely to benefit much from any PPR involvement.

Increasingly, Danish schools are becoming better equipped to deal with common mental health problems of their students, with some schools having their own psychologists and sometimes specialised staff trained in behavioural issues, and with more and more assistant or second teachers becoming involved. This takes place in the context of somewhat smaller class sizes at compulsory school-age in Denmark, as well as a higher number of pedagogical support staff per teacher, than in many other OECD countries (Table 2.1).

School-based support is essential but not enough for pupils needing more comprehensive support including treatment. External advice and support needs to be accessible easily for teachers, pupils and parents. Teachers need to know where pupils can be referred to under what circumstances. In regard to connecting health services with school services, there is still a long way to go in Denmark.[3]

Table 2.1. **Denmark has relatively more pedagogical support for teachers than most other OECD countries**

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 school administrative or management personnel		Ratio of teachers to number of personnel for pedagogical support	
Countries	Mean	(Standard error)	Mean	(Standard error)	Mean	(Standard error)
Australia	24.6	(0.20)	5.5	(0.30)	8.3	(0.61)
Austria	21.1	(0.14)	22.6	(0.82)	24.1	(1.08)
Belgium (Flanders)	17.5	(0.27)	11.7	(0.73)	20.5	(1.63)
Denmark	**20.0**	**(0.22)**	**7.5**	**(0.38)**	**9.1**	**(0.97)**
Estonia	20.5	(0.32)	7.6	(0.21)	10.4	(0.69)
Hungary	20.2	(0.57)	8.3	(0.48)	7.3	(0.69)
Iceland	18.6	(0.02)	6.3	(0.22)	5.7	(0.60)
Ireland	21.9	(0.18)	11.1	(0.41)	15.8	(1.06)
Italy	21.3	(0.16)	7.5	(0.32)	20.4	(3.22)
Korea	34.6	(0.43)	4.9	(0.32)	14.0	(1.12)
Mexico	37.8	(0.55)	5.0	(0.34)	7.9	(0.68)
Norway	21.4	(0.29)	8.3	(0.31)	7.0	(0.41)
Poland	20.8	(0.27)	9.0	(0.48)	9.4	(0.56)
Portugal	21.3	(0.21)	10.5	(0.59)	10.8	(1.64)
Slovak Republic	21.1	(0.26)	4.7	(0.17)	14.3	(1.15)
Slovenia	18.8	(0.18)	7.8	(0.34)	18.3	(1.16)
Spain	21.7	(0.26)	8.8	(0.68)	19.0	(0.91)
Turkey	31.3	(0.75)	10.4	(0.49)	22.2	(2.53)
Average	***23.0***		***8.8***		***13.6***	

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

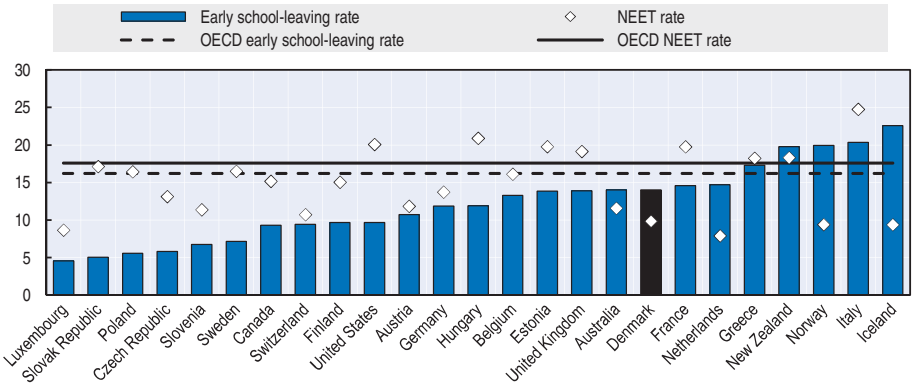
Source: OECD (2010), *Creating Effective Teaching and Learning Environments: First Results from TALIS*, OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264068780-en.

Upper secondary education: improving access, avoiding dropout

School-based services and initiatives and easily accessible municipal supports for more complex problems, including social workers, are critical to ensure that every child completes school and reaches its educational targets. This is important in Denmark in view of a relatively high share of youth, 14% of the 20-24 year-olds in 2009, who leave the school system without an upper secondary diploma; this dropout share is only around 5% in many other OECD countries (Figure 2.3). Many of those early school leavers may have a job – given that the NEET rate (those not in education or training and not employed), at 10%, is among the lowest in the OECD – but they are unlikely to have reached their potential.

Figure 2.3. **Early school leaving is frequent in Denmark, partly because of a high dropout rate from vocational education**

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



Note: OECD total (weighted average) includes all 34 member countries.

Source: *OECD Education Database.*

The high rate of early school leaving is related to the very high rate of dropout from upper-secondary education, especially vocational education and training (VET).[4] The dropout rate from VET schools is roughly 50% and it is particularly high in the first phase *i.e.* during the basic vocational course (once students are in a later phase with an employer contract, dropout is low). Little information is available on the reasons for a VET dropout, which include a wrong school or course choice but also a high share of VET students without the basic qualifications to graduate. Importantly, some 40% of all VET drop outs do not continue any other education. Research by the University of Arhus also suggests that the dropout rate is much higher for students with a mental health problem.

Denmark has long recognised the problems associated with the transition into and the dropout from upper secondary education, as reflected in the recently set education targets.[5] It has a very strong structure in place to ensure young people are not left out and make the right decision after leaving compulsory (lower secondary) school. Municipal Youth Guidance Centres (YGC) are among other things responsible for *i)* counselling youth in their critical transition from lower to upper secondary education, a role which until mid-2004 was in the hands of school-based guidance counsellors *i.e.* teachers working part-time as counsellors, and *ii)* following up on those dropping out from upper secondary education, a new role since 2010 (see Box 2.1 for more details).

Box 2.1. **Effective youth guidance and counselling provided by the municipalities**

There are 45 municipal Youth Guidance Centres in Denmark with more than 100 counsellors to provide guidance services for young people up to age 25. These centres cover the 98 municipalities, with each centre covering a "sustainable" area in terms of the number and variety of youth education institutes and geographical distance. The YGCs focus on guidance related to the transition from compulsory to upper secondary education or to the labour market.

The main target group for the YGCs are those who are not involved in education, employment or training, the so-called "NEET". The YGCs provide outreach services for this group because they are obliged to establish contact with these people and help them get back into education and training or employment. Any other person under age 25 can get in contact with the YGC directly, too.

Guidance activities include individual and group guidance sessions as well as introductory courses and bridge-building programmes to give pupils a clearer idea of the conditions, levels and requirements at different education institutions (there are over one hundred different types of VET schools). These bridge-building programmes combine guidance and teaching and last for 1-4 weeks.

Guidance counsellors have to prepare an education plan to ensure a smooth transition into upper secondary education and employment. Planning involves a series of meetings of the counsellor with the pupil and parents and builds on the pupil's education portfolio, which in turn provides documentation on the pupil's achievements, interests, expectations of the future and wishes in terms of developments.

A special target group are those in the age group 15-17 (*i.e.* under age 18 but no longer in compulsory education) who are guided into upper secondary school and followed up very closely to avoid school dropout. In case of school non-attendance, the guidance counsellor has to get in touch with the parents within five days from the school's notification, and within 30 days some activity needs to be started. The young person can refuse the offer by the counsellor although the aim is an activity agreed with all partners, *i.e.* the counsellor, the young person and the parents. Ultimately, in case of refusal the youth grant could be withdrawn but this rarely happens.

In fulfilling its tasks, YGCs are obliged to co-operate closely with the educational institutions and also the municipal job centre, for which young people in general and the 18-19 year-olds in particular are also a target group (all youths can get guidance from the job centre about labour market questions and their employment options). Additional funding was provided recently for intensified PES-YGC-school co-operation. A database is being developed, which will ensure a full overview of the education and training of each person and enable a quicker identification of vulnerable youth.

Guidance counsellors are responsible for preparing an education plan for each child for the time after completion of lower-secondary school, together with the pupil and parents. This planning process starts several years before the end of compulsory schooling. Then they monitor the transition process and follow up on children not attending school, to avoid early dropouts from upper secondary education. Counsellors are not allowed to provide any

treatment or therapy but they can identify problems and refer the pupil or the parents to specialists, *e.g.* a social worker in case of severe social problems in the family or a psychological service in case of a mental illness.

There are many other initiatives and supports addressing dropout from vocational schools. One of them is the so-called "retention caravan", a project to lower dropout by making the basic vocational courses (which last 20 weeks and include an initial assessment of abilities) more accessible. Many vocational schools offer a mentor service, one of the main roles of the mentor being to help the student in finding a job (which is needed to continue education).

Facilitating the transition into the labour market

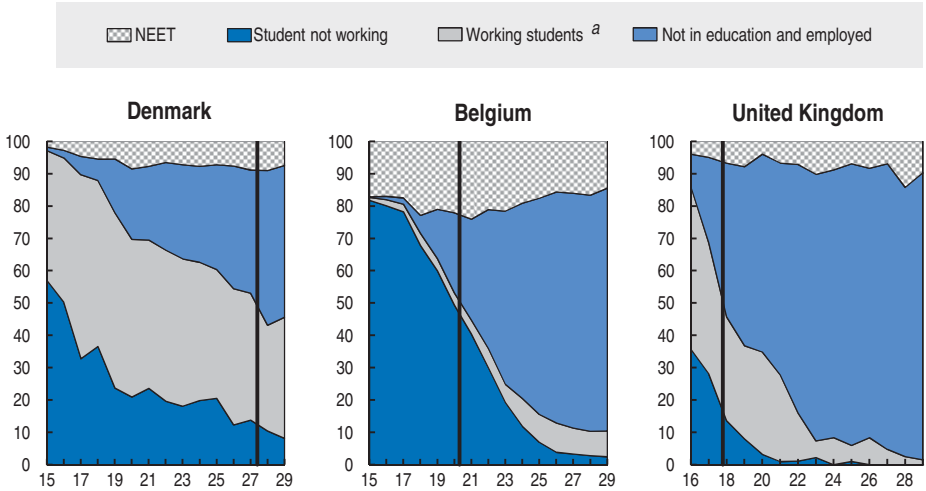
The transition to the labour market and the first job experience is critical for all youths but particularly so for youths with a mental disorder, even if they have reached their educational potential. Denmark seems an outlier in regard to the school-to-work transition in various ways, potentially creating both problems and opportunities for youths with a mental disorder.

A peculiarity in the Danish education system is the very high average age of VET students. While students could enter vocational schools at age 16, many do so much later, with the average *entry* age being around 21 years. This is reflected in Figure 2.4, which illustrates the pathway from education into employment for Denmark and two other countries – Belgium and the United Kingdom – which represent two very different but typical patterns (OECD, 2010a). In Denmark, the median age at which half of the students have left the education system is 27 – compared with 18 in the United Kingdom and around 20 in Belgium. In those two countries, less than 5-10% of a cohort would still be in the education system by age 27. In Denmark, even at age 29, this share is over 40%.

Partly, the Danish situation reflects the strong focus recently on providing upper secondary education to school leavers – with more options today to complete education at an older age (in fact, up to age 40). To a larger extent, however, this pattern reflects a different approach in Denmark to education and employment. From age 16 onwards, the large majority of all students is working; at age 21, for example, two in three Danish students work compared with one in ten in Belgium. Students in the United Kingdom also tend to work but they complete their education on average ten years before the Danes. More will have to be done in Denmark to assure school completion of older students, in view of the YGC focus on the 15-17 year-olds and their overall responsibility for those under age 25 only – an age when more than half of a cohort is still in education. This would also help students in their twenties who have recovered or are recovering from an adolescent mental illness.

Figure 2.4. **Study late while working: the school-to-work transition in Denmark**

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, 2008



a. Including apprenticeship and other work-study programmes. Data on studying (working or not) also include training at upper-secondary or tertiary level started at a later point in life.

Source: European Labour Force Survey 2008.

The Danish school-to-work transition pattern implies that most of those leaving the education system have accumulated considerable work experience, partly required by the school (because vocational schools have a mandatory work component). This also explains to a certain degree why young Danes tend to find their jobs quicker than young people in other OECD countries; the median search time being around six months (Quintini and Manfredi, 2009). With the Great Recession, the unemployment rate of young people doubled to around 14% – posing new challenges for the municipal job centres.

In response to the crisis, job centres have tightened their activation approach for young jobseekers (OECD, 2010a).[6] Young unemployed under age 30 now have to have a first interview with their caseworker after 1-3 months (previously 3-6 months), followed by an activation programme lasting for six months. Very young jobseekers, 18-19 years old, will be helped within a month.[7] There is no particular focus in any of these measures on mental health. However, the earlier follow-up can help people with unidentified mental illness, especially because those additional labour market barriers can be addressed much earlier.

In addition, there is a renewed focus on up-skilling which can help those who have dropped out from school too early, including because of a mental health problem. Jobseekers under age 25 without upper secondary education have to enrol in a mandatory education programme or, if not ready for this step, in activation programmes preparing them for ordinary upper secondary education.[8] There are also special programmes for this age group for those lacking labour market experience, including helping them into subsidised jobs.

Job centres are also increasingly reaching out to higher education institutions and universities by investing in career centres in those institutions. Again, this has the largest potential for those needing extra help – without requiring them to disclose a mental health problem.

Avoiding permanent inactivity

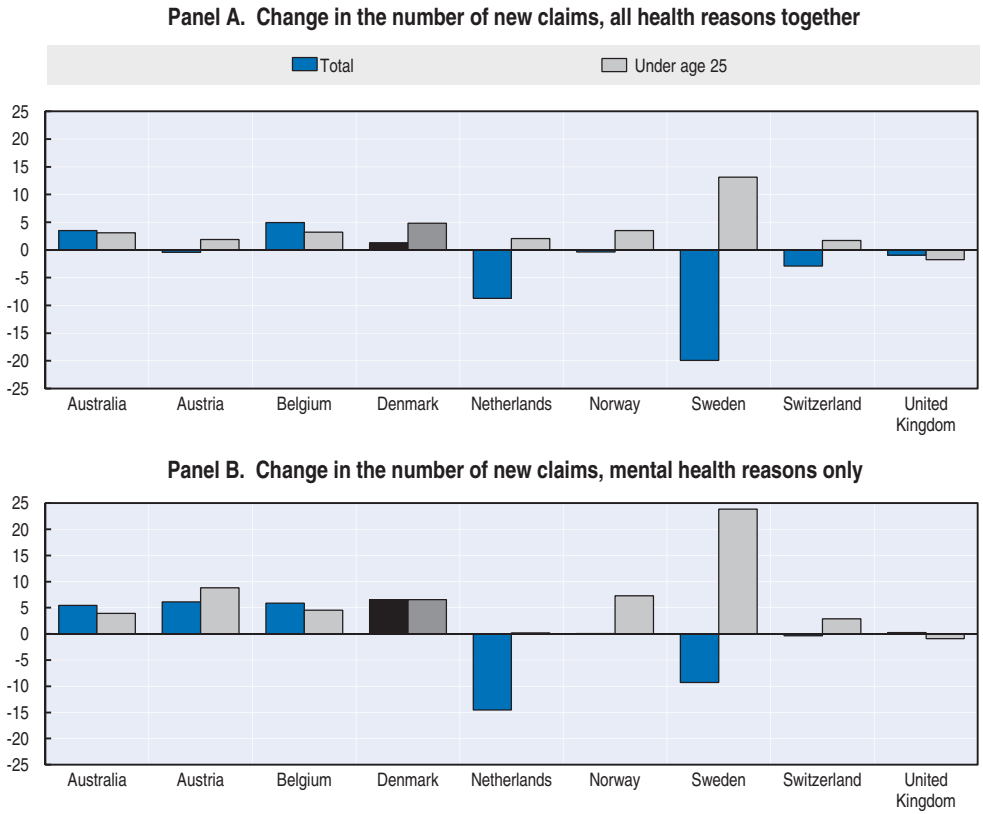
A major issue of concern in Denmark is the large and increasing number of young adults under age 25 moving onto disability benefit, with very little or no work experience (Figure 2.5, Panel A). Contrary to other OECD countries with a similar problem, these young people are not transitioning from a special child benefit but moving onto disability benefit through the regular procedure and with the general eligibility criteria. The majority of these young adults claiming a disability benefit suffer from a mental disorder. For all age groups, the fastest growth in disability benefit claims is recorded for those with a mental disorder (compare growth rates in Panel B with those in Panel A).

In response, the government together with the opposition has agreed on a major reform of the disability benefit scheme. In short, the intention is to largely abolish disability benefit for those under age 40 (except for a few people totally unable to work), and instead introduce a *rehabilitation model* for each eligible person.[9] The following are the main characteristics of the planned rehabilitation approach:

- The rehabilitation model will involve, for the first time, the health sector (municipal and regional) and the relevant labour market institutions, as well as social services and the education sector. Overall responsibility lies with the municipal job centre.
- An interdisciplinary rehabilitation team will be established in every municipality to ensure the integrated approach will work in practice.
- The rehabilitation team will discuss needs, make recommendations and co-ordinate actions, but it will not take any decisions (which will instead be taken by each of the relevant institutions towards an agreed goal).

Figure 2.5. **In most countries, including Denmark, disability claims increased fastest among young people and those with a mental disorder**

Average annual growth rate over the past decade in the number of new disability benefit claims, total working-age population versus young adults under age 25[a,b]



a. Trends refer to the following periods: Australia 2004-10, Austria 2005-09, Belgium 1999-2010, Denmark 1999-2011, Netherlands 2002-09, Norway 1992-2007, Sweden 2003-10, Switzerland 1995-2009 and the United Kingdom 1999-2010.

b. Data for Norway do not include the temporary disability benefit. Data for Belgium, the Netherlands and Sweden include mental retardation, organic and unspecified disorders which, on average across the other countries, account for 13.4% of the new claims due to a mental disorder.

Source: OECD calculations based on data provided in the OECD questionnaire on mental health.

- The rehabilitation model will last for up to five years depending on the client's needs. Everyone potentially benefitting from this procedure will no longer be allowed to move to disability benefits.
- The model involves a co-ordinator, whose role is to co-ordinate action and navigate the client through the system. This could be a

job centre caseworker; or someone else from the municipality; or a consultant from outside *e.g.* based at the workplace (the decision on who will be authorised to be a co-ordinator has yet to be taken).

- During rehabilitation, people will continue to receive whatever benefit they are on or, if not entitled to any benefit, a "minimum income" at the social assistance level.

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

The new approach is promising but it is too early to tell how well it will work in practice and what its outcomes will be. Savings are estimated to be in the order of EUR 250 million annually in 2020 (470 million in the long run), under the assumption that a significant share of those who would otherwise move onto disability benefit will instead work in the open labour market.

The new approach aims to avoid pushing young adults into inactivity too easily and too early. This could be particularly helpful for the many claimants with a mental disorder because for this group in particular inactivity is likely to worse their condition whereas rehabilitation and employment can contribute to improved health and wellbeing.

Conclusions and recommendations

Denmark has well-developed policies in place to help youths and adolescents with a diagnosed severe disability that limits their chances in education and life more generally. This should benefit youngsters with a severe mental disorder but not necessarily the large number of those with mild or moderate mental disorders, which are often unidentified. Instead, this latter group depends on general school services for providing assistance, which are better than in many other OECD countries but are still not well connected with other services, especially the health system.

With its municipal Youth Guidance Centres, Denmark has a very strong model in place for helping young people from lower into upper secondary education and further on into the labour market and, since recently, for preventing dropouts from upper secondary education. A challenge remains, however, for these centres and more generally, in helping and monitoring

older students (those aged 25 and over), in view of the extremely late age of entry into and completion of upper secondary education.

Denmark has reacted very quickly to rising youth unemployment in the course of the recent financial crisis. While there is no focus in any of the new activation measures on young adults with a mental disorder, all of these measures should help those with a moderate mental disorder to find work or remain connected to the labour market. Denmark is also introducing a major new reform to tackle the structural increase in disability benefit claims by young people, most of them with a mental disorder. It remains to be seen how the rehabilitation approach for those under age 40 will be implemented in practice and how effective the planned integration of health, social and employment services will be. In the best case it could prove to be a blueprint for disability benefit reform more generally, in Denmark and elsewhere.

Continue to develop school-based supports

- *Empower teachers and school principals*. Teachers and school principals have a key role in the Danish system in providing a positive school environment and monitoring students' wellbeing. Teacher competencies should be improved by including components on identification of, and ways of dealing with, mental health problems in the initial curriculum, and by offering mandatory continued training on mental health issues for current teachers and school principals. Rightly interpreting early signs, such as persistent behaviour or social contact problems, can assure early intervention.
- *Provide sufficient resources for students with common mental disorders*. The municipal educational-psychological advisory service (PPR) has great potential in theory in identifying and addressing common mental health problems of pupils. This potential has yet to be harvested by increasing the resources invested into PPR; currently the focus of the PPR is on people with severe disorders in need of special supports.
- *Better connect school services with health care services.* It is important for teachers and school authorities (and for students and their parents) to have easy access to psychological and psychiatric treatment.

Address the high VET dropout

- *Provide a better evidence base.* More evidence is needed on the share of students with a mental disorder in school dropouts as well as among VET students in various age groups, and on the reasons

for school dropout. More generally, the implications for students with a mental disorder of the Danish "late study-late completion" syndrome need to be better understood, and the impact of the recent doubling of the risk of unemployment on the chances of finding a first job for a young adult with a mental disorder investigated.

- *Raise the school attendance and completion rate.* Youth Guidance Centres (YGCs) have a strong role in counselling students into upper-secondary education and following up in case of dropout. The effectiveness of YGCs should be evaluated and improved. In view of the late-study culture, the YGC obligation should be extended to age 30 (now age 25) and include assisting youths when they apply for the main vocational course and seek an apprenticeship in a firm. Recent initiatives providing a mentor service to students in vocational schools and making vocational courses more accessible for students with mental health problems (*e.g.* less school-based training leading to a partial qualification) should be extended.
- *Help dropouts to access the labour market.* School dropouts with a mental disorder should be helped quickly and not be left alone for too long. Labour demand for this group could be increased by reduced labour costs for employers hiring youths with incomplete upper-secondary education who often suffer from a mental health problem. The recently introduced mandatory enrolment in education programmes (or preparation programmes) which will reach many of those with a mental disorder should be strictly monitored and adapted to fit the needs of this group. More generally, the PES will need more resources to help youths with a mental health problem.

Closely monitor forthcoming disability benefit reform for the under 40s

- *Rigorously implement the forthcoming disability benefit reform.* Replacing disability benefit by a rehabilitation model has the potential for being a step from permanent exclusion to labour market inclusion. However, this will only be the case if the model is implemented in an active manner to prevent the rehab benefit from turning into a disability benefit with a new name, *i.e.* to prevent the actors from parking people on rehab benefit.
- *Rigorously monitor reform implementation and adjust as needed.* The new approach could fail easily. Particular attention will have to be given to understanding whether *i)* the various actors have the right incentives; *ii)* roles and responsibilities are clear; *iii)* better guidelines are needed; and *iv)* the critical rehabilitation co-ordinator has sufficient power over the partners in the rehab model.

Notes

1. Once diagnosed as being in need of special support, help can be manifold and comprehensive, including for example consulting assistance relating to the illness; practical and pedagogical support in the home; family therapy or specific treatment; residential accommodation for the custodial parent and the child; relief care arrangement; appointment of a welfare officer for the child; and appointment of a permanent contact person for the whole family.
2. Compulsory education in Denmark (primary and lower secondary) lasts ten years, from age 6 to age 16. Until the end of compulsory education, the education system is comprehensive and general with all children following the same curriculum in the same school.
3. The Ministry of Social Affairs and Integration has initiated an interesting project in post-compulsory vocational schools which includes open-access psychological therapy for students. It will be important to evaluate this initiative.
4. After completion of compulsory school at age 16, about half of young people choose to attend a general academic upper-secondary school and the other half one of the vocationally oriented schools preparing for a particular profession. Upper-secondary education generally lasts for three years.
5. The government's aim is to provide 95% of the population with upper secondary education (now 82%) and 50% with tertiary education (now 48%).
6. Intensifying activation in the midst of an economic crisis is made possible in Denmark through a regulation by which ALMP spending is increased when unemployment goes up.
7. The new fast-track employment interventions for youths are stimulated by an experiment run in Denmark during 2005-06 on early intervention and intense counselling for the newly unemployed, which showed good results, especially for young unemployed (OECD, 2010a).
8. Job centres also offer vocational programmes to those under age 40, who have not had a chance to undertake higher education ("up-skilling the unskilled").
9. The recently agreed disability benefit reform which will come into force in January 2013 also includes changes for new claimants over age 40, changes for those on benefit already, and changes to the flexjob scheme; these reforms are discussed in later sections of this report.

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Chapter 3

Flexicurity, productivity and the Danish work environment

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 impact of negative attitudes towards workers with a mental disorder and the link between working conditions and mental ill-health. It then discusses prevention and early-intervention-at-work strategies to address challenges in the psychosocial work environment. Finally, it looks at employer responsibilities and incentives to tackle sickness absence of the workforce and the involvement of doctors in this process.

Mental ill-health is a risk factor for failing to access or complete higher education which can reinforce other difficulties in finding and remaining in employment. Nevertheless, *the large majority of those with a mental disorder have a job*. This implies that the workplace has potentially a very important role to play to ensure that *i)* the negative impact of a mental disorder on work performance is minimised; *ii)* those who take sick leave because of a mental illness can return to their job quickly; and *iii)* the work environment itself does not contribute to poorer mental health. Danish policy addresses several of these issues – with an increasing focus over the past decade on the psychosocial work environment – but there are still a number of areas for further improvement in the system.

Negative attitudes towards co-workers with a mental illness

Stigma and discrimination faced by people with a mental disorder can harm their employment prospects and job performance. This appears to be a more serious issue than for other types of illness and disability, and may be explained by a lack of understanding of mental illness and its implications. A recent survey of the Danish National Institute for Social Research finds that 56% of all workers are, to a large or at least some degree, reluctant to work with a colleague with big fluctuations in mood (Table 3.1). This compares with only 15% saying the same about a blind co-worker and less than 10% about a co-worker in a wheelchair. Stigma has fallen slightly in the past five years but remains very high.

Other surveys with a broader mental health question suggest that, in 2009, 36% were reluctant to work with a co-worker with *any* mental illness and 21% believed that hiring such a person would reduce the quality of work, compared with 27% two years earlier (Thomsen *et al.*, 2011). Data on corresponding attitudes of employers are not available for Denmark but data for other countries suggest views of employees and employers are similar. Consequently, research consistently finds that a mental disorder reduces the hiring chances significantly and in turn increases unemployment duration and disability benefit claims (Rosholm and Andersen, 2010).

In recognition of the need for long-term efforts to change these widespread negative attitudes, the Danish government set aside significant funding (around DKK 12 million) for an anti-stigma campaign in 2010-11 to address fears and prejudices against people with mental health problems. The campaign aims to reach various arenas; workplaces, youth & education, and media being among them. Evaluations on every component of the campaign are in preparation. The Danish government has allocated further DKK 7 million to continue the national campaign in 2013-16.

Table 3.1. **Attitudes towards co-workers with mental illness are improving but stigma remains very high**

Proportion of workers aged 16-64 (wage earners or self-employed) who are reluctant to work with co-workers with different types of health problems

	Would you be reluctant to work with a colleague who ... (2010)			Would you be reluctant to work with a colleague having big fluctuations in mood?		
	... is blind?	... is sitting in a wheelchair?	... has a fluctuating mood?	2005	2008	2010
Yes, to a large degree	4.2	2.6	18.6	25.7	22.5	18.6
Yes, to some degree	11.5	6.1	37.8	40.0	42.1	37.8
No, almost not	10.4	9.2	14.6	10.2	12.3	14.6
No, not at all	70.2	78.9	24.0	19.7	20.0	24.0
Don't know	3.7	3.2	5.2	4.4	3.1	5.2

Note: Changes over time are significant at the 10% level.

Source: Thomsen, L.B. and J. Høgelund (2011), *Handicap og beskaeftigelse. Udviklingen mellem 2002 og 2010*, Report No. 11:08, Danish National Institute for Social Research, Copenhagen.

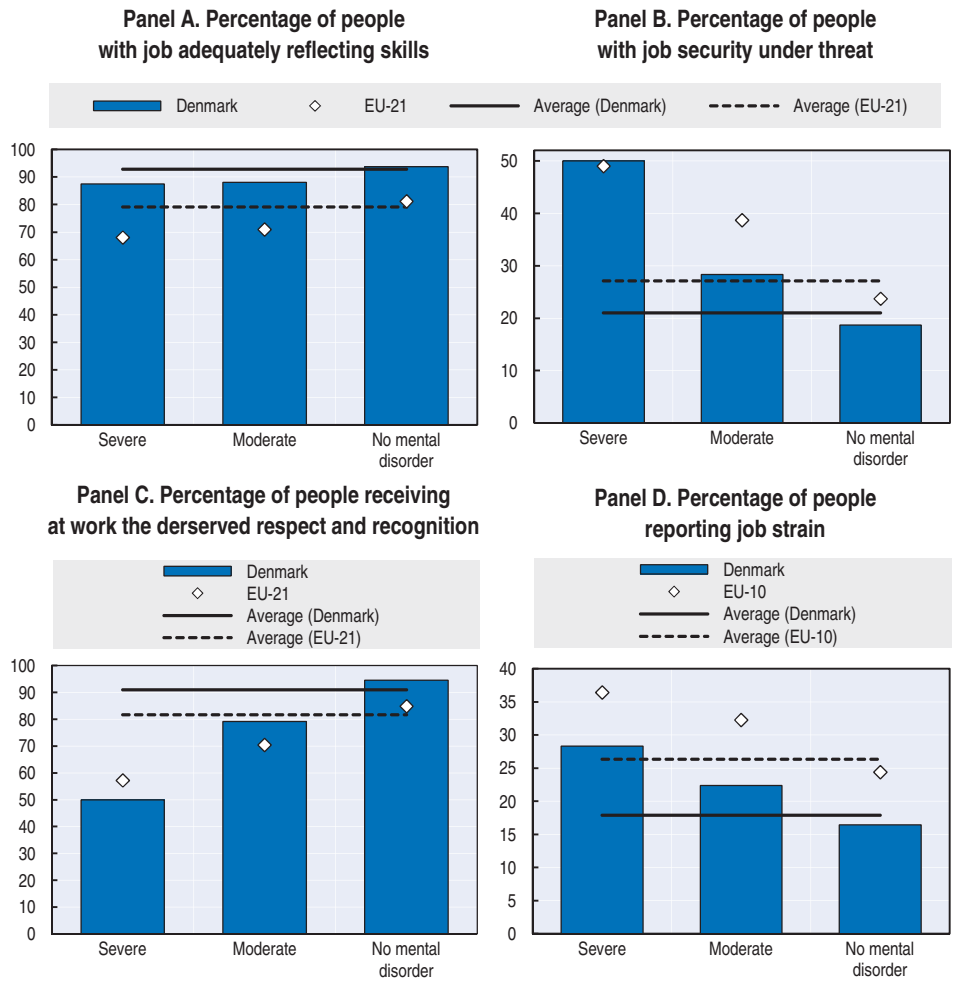
The link between working conditions and mental ill-health

OECD (2012) concluded that workers with a mental disorder tend to work in jobs of poorer quality; job strain can have a significant negative impact on the worker's mental health; over time, self-reported job strain has increased in most occupations; and good management is one of the key factors in assuring good-quality employment and mitigating workplace mental health risks.

Data for Denmark corroborate these findings although, by and large, working conditions on average appear to be better in Denmark than in many other countries. As in other countries, workers with a mental disorder are more likely to report job strain, *i.e.* to work in jobs that are psychologically demanding but with limited decision latitude – with a 12 percentage-point difference between workers with a severe and those with no mental disorder (Figure 3.1, Panel D). The overall level of job strain for all workers is much lower than on average across 21 European countries. Furthermore, workers with a mental disorder more often report job insecurity (Panel B) and less often receive the recognition they deserve (Panel C), with large differences by degree of severity of the mental disorder. Yet, despite comparatively lenient employment protection (in 2008, Denmark scored as 9th most lenient country on the OECD employment protection legislation indicator; see Venn, 2009), Danish workers with a moderate or no mental disorder feel their jobs to be more secure than on average across the 21 countries. There are very small differences by mental health status in the extent to which jobs match adequately the person's actual skills (Panel A), and in this regard Denmark is also doing better than other countries for all groups of workers and those with a severe mental disorder in particular.

Figure 3.1. **Workers with a mental disorder work in jobs of slightly poorer quality**

Selected job-quality indicators for workers with a severe, moderate or no mental disorder, in Denmark and on average over European OECD countries in 2010



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

Source: OECD calculations based on Eurobarometer 2010, except Panel D based on European Working Conditions Survey 2010.

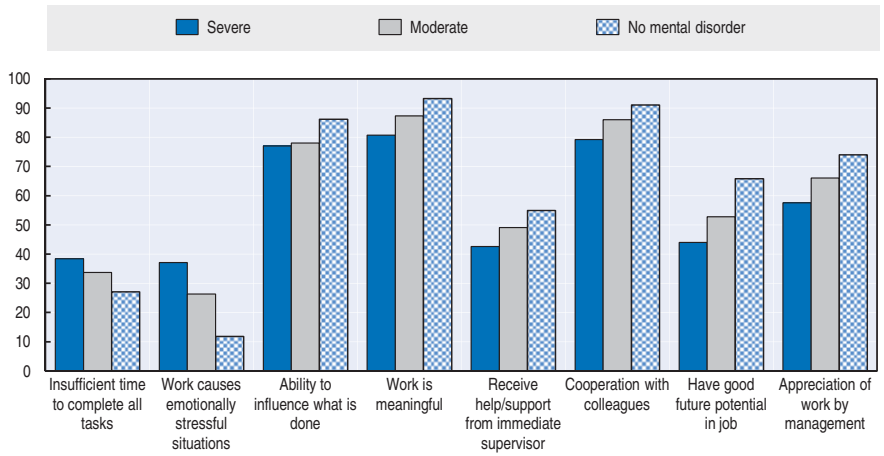
Figure 3.2 highlights further the association between poorer mental health and poorer working conditions. For example, workers with a mental disorder systematically report having less time to complete all their tasks; more work-caused emotionally stressful situations; less support from their

supervisor; less co-operation with their colleagues; and less appreciation of their work by management.

Simple associations like these can be due either to workers with poor mental health finding poorer-quality jobs (or perceiving them as of poorer quality) or poor-quality jobs causing a worsening of mental health. Danish research on the link between the psychosocial work environment and mental illness suggests that workplace factors do indeed have a large impact on mental health and sickness absence, with large differences by gender.[1] Extensive research from the Danish National Research Centre for the Working Environment has identified six psychosocial stress factors: low control over one's work and working conditions; low meaning of work; low reward (in terms of wages, career opportunities, recognition) relative to effort; low predictability of future developments; low social support from managers and colleagues; and inadequately high or low work demands (in terms of workload and the pace of work). These stress factors increase the risk for a worker to develop mental health problems while at the same time, the data suggest that workers with a mental disorder fare worse on all of these six domains, amplifying the risk.

Figure 3.2. **Workplace factors show a systematic link with mental health status**

Share of persons who replied positively to various working conditions, by severity of mental disorder, 2005



Source: Danish Health Interview Survey (SUSY) 2005.

Addressing psychosocial work environment challenges

These findings suggest a dual strategy is needed to address challenges in the psychosocial work environment (PWE): first, a strategy of prevention, which has been developed already in Denmark within the field of health and

safety at work; and, second, a strategy of early intervention at work for workers who face mental health problems already, an area in which Denmark will need to do more.

Preventing mental distress

Workplace health and safety policy in Denmark is regulated by the Working Environment Act and overlooked by the Working Environment Authority (WEA). The social partners through the system of industrial relations have a key role in this regard through various instruments dealing with the relationship of the management and the workforce at company level. One such instrument is the Cooperation Agreement, a framework agreement which establishes that every company with 35 or more employees has to have a Cooperation Committee with mutual duties for management and employees' representatives of informing and consulting each other in regard to most aspects of a company's working conditions – with the PWE more recently being one of the key topics for those Committees.

Legal provisions require that employers manage (prevent or control) psychosocial risks in the workplace. Through an agreement in 2007, the WEA became responsible for inspecting the PWE in all enterprises and assisting companies in making an action plan to solve identified problems. A Prevention Fund was established to which enterprises can apply for funding projects to prevent an unhealthy PWE. Use of these funds is currently under review, with the aim to increase the focus on preventing exhaustion of people from the labour market and on including people with a mental illness into the workforce. PWE is one of three priority areas in the national working environment strategy until 2020. One of the main goals of the strategy is to reduce the share of employees experiencing psychosocial strain by 20% by 2020. A monitoring programme has been developed by the National Research Centre of the Working Environment to assess whether the labour market is on the right track towards achieving this goal.

To meet the new obligations and expectations, the WEA developed a strategy for inspecting the PWE of Danish companies and new guidance tools for identifying PWE problems, which are seen as quite effective (see Box 3.1 for more details). Considerable human and economic resources have been invested in delivering the strategy, resulting in a substantial increase in improvement notices (1 053 notices on PWE problems in 2008 compared with 245 in 2006). Nevertheless, too little time is devoted to the actual inspection of workplaces and companies. This more general resource problem was also identified in a recent evaluation of the WEA (Senior Labour Inspectors Committee, 2008). Two years is too long a gap between an inspection identifying a problem and a follow-up inspection controlling the implementation of measures addressing the problem.

A remaining challenge identified in a preliminary evaluation of the new strategy is to bridge the gap between the focus by the current guidance tools on just one risk factor at a time on the one hand and the complexity and interaction of the whole PWE in a given enterprise on the other.

Box 3.1. **A strategy for inspection of the psychosocial working environment (PWE) by the Danish Working Environment Authority**

Since 2007, the WEA is responsible for inspecting the PWE in all enterprises. This meant a big shift from the more traditional health and safety focus of the WEA. Based on the findings of Danish research, the WEA has developed 24 sector and job-specific guidance tools. Each guidance tool describes the prevalence of risk factors and the resources of a company to prevent problems – the aim being for each company to seek a balance between risks and prevention resources. The tool also describes possible organisational consequences of an imbalance between risks and resources, such as bad reputation, loss of commitment, long delays and complaints from customers, high turnover rates or long-term sickness absence rates.

WEA inspectors have been trained in how to use the guidance tools and how to assess and evaluate the health and safety risks on PWE. The job of inspecting PWE has been facilitated through method descriptions and instructions, by templates for how to prepare improvement notices (in case improvements are needed in a company) and through sharing of best-practice examples and improvement notices. In each of the four regional WEA inspection centres, a task force has been established consisting of 6-8 highly skilled PWE inspectors who assist other inspectors in assessing PWE problems, preparing improvement notices and giving guidance to enterprises that have received an improvement notice.

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

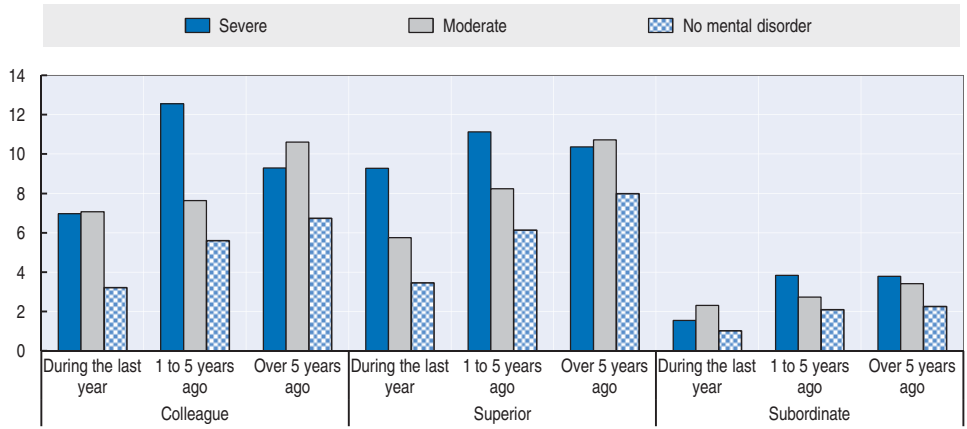
Similar to the steady shift in health and safety regulations towards focussing on PWE issues, the workers' compensation scheme is also under gradual modification; with an ongoing debate as to whether and what types of mental illnesses should be included in the list of occupational diseases. At the moment, post-traumatic stress disorder is the only mental illness on this list. However, other mental disorders not on the official list can also be covered in actual workers' compensation cases upon the recommendation of the Occupational Disease Committee which would submit such cases to medical consultants specialised in psychiatry. The Committee is currently processing a number of cases regarding depression caused by stress.

Every Danish company has to conduct a workplace risk assessment using staff surveys and other tools. The focus of these assessments on PWE

and stress at work is increasing. Predominantly, this risk assessment is about *organisational* factors, including working hours, quality-time conflicts and the like. *Individual* work situations can be included if they are found relevant for the assessment of health and safety in the workplace. Workplace conflicts and their implications are unlikely to be addressed in such risk assessments. Workplace conflicts affect workers with a mental disorder more than others: conflicts with a colleague or a superior are reported twice as often as by those without a mental disorder, the difference being equally large for conflicts that have occurred in the past five years (Figure 3.3). The WEA carries out inspections in regard to bullying and harassment. It does not intervene in workplace conflicts unless the integrity of one of the two parties involved is violated. Law suits would also be possible as the ultimate sanction but in practice legal cases are not very common in Denmark.

Figure 3.3. **Workplace conflicts in the past five years correlate with mental ill-health**

Share of persons who experienced a conflict in the work environment, by severity of mental disorder, 2005



Source: Danish Health Interview Survey (SUSY) 2005.

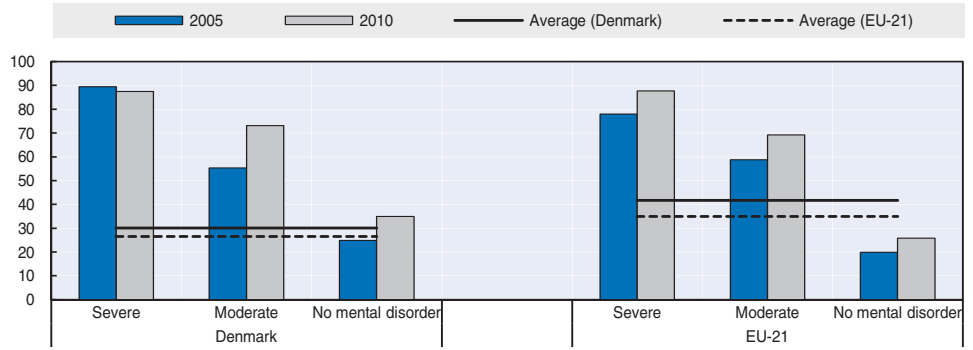
Helping those struggling at work

To secure good working conditions to prevent workers from being worn out by work emotionally and mentally is one side of the coin. The other side is to tackle mental health issues when they arise – be they caused by, related to or unrelated to work – and their implications on the worker's work performance and productivity. Figure 1.7 suggests that reduced productivity because of a health problem is very widespread, especially among workers with a mental disorder. Not only is the proportion of workers reporting health-related performance issues high but it has increased over time among

all workers in both Denmark and on average across OECD countries, and most among workers with a moderate mental disorder (Figure 3.4).

Figure 3.4. **Reporting of performance problems at work has increased in the past five years**

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



Source: OECD calculations based on Eurobarometer 2005 and 2010.

This suggests an increasing number of workers with a mental disorder struggle at work, facing problems that reduce performance and output but do not necessarily lead to the worker being off sick. It could also indicate that workers with a moderate mental disorder were affected most by the economic crisis.

To what extent are Danish companies addressing these workplace challenges? Many companies contract a private working environment consultant which provides all kinds of services, similar to those provided by occupational health services in other countries.[2] These consultants conduct classical risk assessments but also individual tasks, *e.g.* for workers on sick leave, thereby acting as a bridge between the worker and the employer.

Typically, some 40% of the work of a working environment consultancy company (WECC) would be on legal issues around the observance of the Working Environment Act. The remaining 60% would be spent looking at additional "voluntary" activities such as the interpretation of classical risk assessments; the organisation of an education strategy; and individual tasks for people on sick leave. For the latter, a WECC would have a psychologist providing confidential services to sick workers who would be informed by the municipality of the possibility to talk to their WECC's psychologist. It remains questionable how open a worker would be in sharing information

with the WECC which is contracted by the employer. In principle, talks with the WECC are confidential and information would only be shared with the employer with the agreement of the worker. However, the WECC also has annual talks with the employer where they could, for example, inform the employer about frequent stress-related complaints in their company.

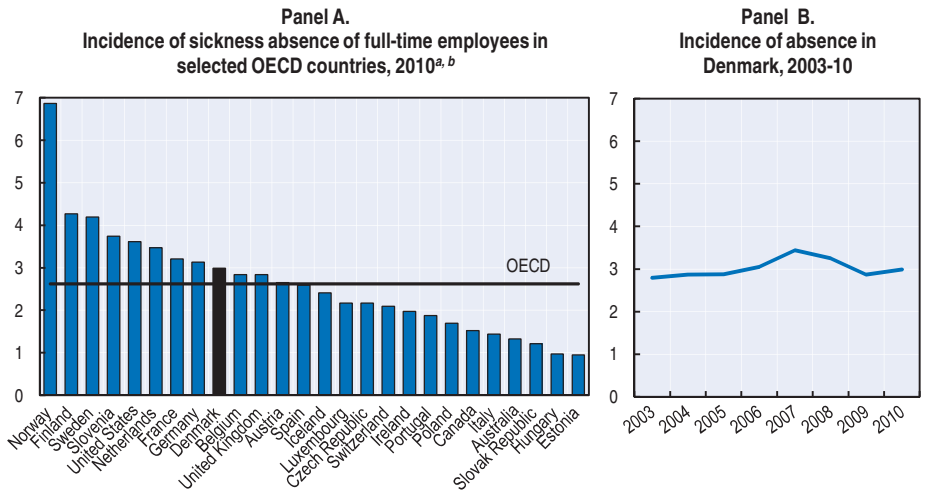
Contracting a WECC is not mandatory. Bigger companies will often have their own in-house working environment consultant, based in the human resource department. In addition, Danish companies with ten or more employees are required to have an internal occupational representative – meaning there are generally three potential contacts for a worker facing problems at work: *i)* the line manager or the management of the company; *ii)* the occupational representative; and *iii)* the in-house or external working environment consultant. Nevertheless, chances are high that workers with a mental disorder would opt to hide their problem – especially if they have had previous experiences of dismissal under such circumstances. After all, depending on the length of the employment contract, workers can be dismissed relatively easily and quickly (compared to many other countries) in case of long-term illness, with or without formal sick leave.

Effective sickness management at the workplace

Recent policy changes have done little to address performance-at-work problems of workers with a mental health condition. However, sickness absence monitoring and absence management was made more stringent. This is essential in view of two aspects. First, Denmark's incidence of sickness absence is lower than in the other Nordic countries but higher than on average across the OECD (Figure 3.5, Panel A). Despite a series of reforms, Danish absence rates have changed very little in the past decade (Figure 3.5, Panel B). Secondly, after a worker has been dismissed it proves much harder to help the person back into work. Evidence suggests that in Denmark quite a large share of people moving onto public sickness benefit (following a two-week period of continued wage payment by the employer) and turning to the municipal job centre has lost their employer already, or is losing the employer rather quickly. This means that action building on the employer-employee relationship – one of the biggest assets in an effective return-to-work strategy – needs to start very early.

Figure 3.5. **Sickness absence in Denmark has changed very little in the past decade**

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



Note: Absence incidence is defined as the share of full-time employees absent from work due to sickness and temporary disability (at least one day of the work week). Data are annual averages of quarterly estimates. Estimates for Australia and Canada are for full-week absences only.

a. 2004 for Australia, 2007 for Iceland, 2008 for the United States and 2009 for Ireland.

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

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

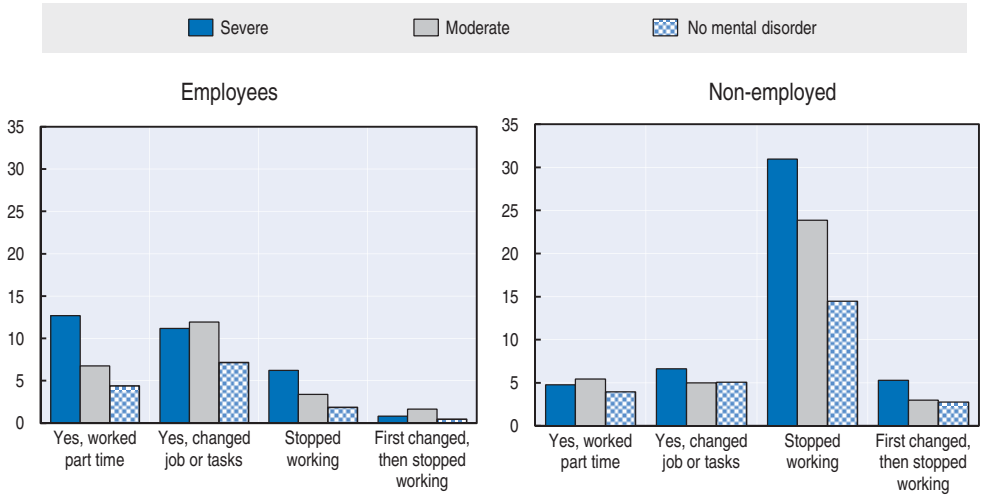
Figure 3.6 shows that this need for early action is particularly critical for workers with a mental disorder: one in three of those non-employed with a severe mental disorder and one in four with a moderate disorder report that they have once stopped working because of a health condition, compared with 15% among those without a mental disorder. Changes in work tasks or working hours were much less frequent for all groups of previous workers, suggesting that for this group job separations were generally more frequent than changes in working conditions. Among current employees, very few have ever stopped working while around 10% have changed job or tasks and another 5-10% started to work part-time because of a health problem; these shares are generally higher for those with a mental disorder.

There is a general shift in Danish sickness policies to involve the employer more actively in the return-to-work process. Since 2009, within four weeks from the first day of absence the employer is required to contact the employee regarding the possibilities of returning to work – including to

fill in a form and trying to find out what the problem is (with a focus on the work tasks, not the illness). The employer then has to prepare a retention plan, together with the employee and on the basis of the recently introduced so-called *workability record* of the GP (see Box 3.2 for more details). Within eight weeks, the employee has to have a first personal meeting at the municipal job centre regarding return to work (more on this in Chapter 4). Also within eight weeks, the job centre must contact the employer regarding the employee's retention possibilities and inform the employer about initiatives that could facilitate a return to work.

Figure 3.6. **Once people have lost their job, reintegration becomes much harder**

Share of current and previous workers who ever experienced a change in their working conditions due to an illness, a disorder or an injury, by current employment and mental health status, 2005



Source: Danish Health Interview Survey (SUSY) 2005.

There is also more effort in recent years to involve doctors in the sickness retention process – building on the workability record – and to bring together employers, doctors and job centre caseworkers. This is done through meetings involving all three of them (note that general practitioners are reimbursed for attending such a meeting). However, such meetings rarely occur in practice.

A problem therefore is the voluntary character of recent improvements. For example, there are hardly any sanctions for any of the actors for not providing a retention plan, preparing a poor workability record or failing to attend a prescribed meeting. To date, implementation of the new regulations is weak and most rules are of a voluntary nature. There is little discussion in Denmark on what is needed by employers to fulfil their role vis-à-vis sick workers and very little monitoring of what an employer does.

Box 3.2. **A new workability record supplementing the sick note**

Since 2009, when requested (i.e. in cases where the employer and the employee are not sure on the workability of a sick employee) general practitioners in Denmark are required to issue a workability record. The record indicates whether or not the patient is fit for work by looking at what the patient *can* do instead of focusing on the illness and the particular diagnosis. The goal is to support the patient in remaining at work by describing the tasks and functions the patient can conduct without making his or her health problems worse. The workability record also includes an estimate of the duration of the limitation.

Administratively, the workability record is a simple two-page form: page one being filled by the employer and the employee, and page two by the general practitioner in consultation with the worker. Where necessary, a specialist doctor – for example, a psychiatrist – can also be involved. The record has to be forwarded to the job centre two weeks after the onset of the absence (when public sickness benefit payments kick in).

There are no guidelines for general practitioners on how to prepare these records, but the Danish Medical Association has launched a government-financed e-learning course about stress, anxiety and depression; how patients can remain at work; and how doctors can support their retention. The workability record is currently being evaluated. Initial results suggest potential but also weaknesses in the way the records are compiled due to a lack of directions on how they should be completed; as a result, there is large discretion and room for doctors to be pushed by their patients to certify that they are unable to work. So far the new approach has failed to turn around the continued trend increase in sickness absence duration.

A welcome initiative is the recently published guideline for managers in dealing with workers who are on sick leave with a mental health problem, which aims to provide simple tools on how and when to keep or get in touch with the employee and how to handle situations where the employee does not want to talk and/or is not accepting the situation.[3] Some of this could be useful for workers with a mental health condition who are not on sick leave yet as well *i.e.* workers still at work but struggling.

Another recent initiative, as in other Scandinavian countries, is a strong focus on gradual return to the workplace of sick employees through *partial sickness benefit* which is only possible with good employer cooperation. This can be done in a very flexible way, either in terms of hours (from one hour upwards) or work tasks: the employee is paid full-time and the (partial) sickness benefit is paid to the employer to compensate for productivity loss (without any employment contract issues being involved). However, Danish data suggest it is more difficult for workers with a mental disorder to return to their workplace gradually and that gradual sick leave has helped all workers to return faster, except for workers with a mental disorder (Høgelund and Holm, 2011). The reasons why gradual sick leave does not facilitate a return to work among workers with a mental disorder are not

clear and resolving this should be a high priority for research. More generally, it appears that for people with a mental disorder avoiding absences is a better strategy than aiming to help them back to work on a gradual basis: many mental illnesses – moderate ones in particular – tend to worsen very quickly when the person is away from the regular work routine.

Conclusions and recommendations

Negative attitudes towards workers with mental illness persist and will continue to be a barrier to better labour market inclusion and better work performance of people with such an illness. Working conditions overall seem to be better in Denmark than in other OECD countries. However, as elsewhere, workers with a mental disorder tend to work in jobs of slightly poorer quality.

Policy in Denmark has moved significantly in two ways to better address mental health issues in the workplace. First, in terms of prevention of psychosocial risks at work, through a gradual extension of existing workplace health and safety regulations and tightened procedures in the industrial relations system; a remaining problem is that psychosocial risks continue to be underrepresented. Secondly, by a steady development of the sickness monitoring process and more involvement of employers in this process; the problem here is a weak implementation of the new legislation.

The area in which Denmark will have to catch up most is in helping the large number of workers who are ill enough to face major performance problems while at work, but not ill enough to take any longer-term sick leave. Sick leave is a good indicator to identify people with looming problems. However, at the moment people move into sick leave, support (to the extent it is given) is coming too late for many.

Inspect psychosocial workplace risks thoroughly

- *Further increase the focus on the psychosocial working environment (PWE).* Denmark has a comparatively strong focus on PWE in its health and safety regulations and strategy and its industrial relations system. Nevertheless outcomes fall short of the opportunities and previous goals remained unachieved. PWE issues need to be addressed more forcefully by employers and the social partners.
- *Monitor employer action and inspect employer obligations.* Employers are essential in securing a healthy PWE. The conduct of PWE risk assessments should be monitored and employers be helped with better guidance on how PWE health risks can be evaluated and addressed. Special support should be given to small and medium-

sized enterprises which will often find it difficult to apply existing sector and job-specific guidance tools and therefore need to have access to outside expertise supplied by occupational consultants.

- *Shift more resources of the Working Environment Authority towards PWE issues.* The WEA has developed a strong strategy for PWE inspection with good potential. However, it is slow in shifting resources for traditional health and safety tasks to the new PWE tasks. PWE inspections could be more frequent, with swifter follow-ups where problems have been identified. Additional resources may be needed to develop enterprise solutions; this could be done by further raising the budget of the Prevention Fund available for companies for projects aimed at securing a healthy PWE.

Help those struggling at work with a mental illness

- *Strengthen retention support provided by working environment consultant companies (WECCs).* WECCs have multiple roles, including legal working environment checks but also voluntary sick leave interventions. Probably least developed is their role as conflict managers and facilitators of work and workplace accommodation, to avoid absences as much as possible. This role could be developed to one of WECC's key roles, in view of the high productivity losses of workers with a mental disorder. WECC psychologists are very well placed to help employers address mental health issues at work. Employees should be made aware of the confidential information and support the WECC can provide in this regard.

- *Improve co-operation between managers, working environment consultants and occupational representatives.* A worker facing health-related productivity losses has three potential contacts: the line manager or the management of the company, the occupational representative, and the working environment consultant. The employee can and should be able to choose who to contact, or who to contact first. However, problems are best addressed by stronger cooperation between the three. Line managers and occupational representatives would benefit from systematic training on how to handle issues related to mental ill-health of a worker.

Further improve sickness management

- *Implement employers' sickness management responsibilities rigorously.* Denmark has introduced and gradually tightened a number of obligations for the employer to support a swift return to work of a sick employee. This process has to be implemented

strictly. So far, the tighter regulations have not resulted in a drop in sickness absence rates. Employers need to be supported in fulfilling their role and actions, e.g. by a one-stop contact in the job centre in the municipality where the business is located. Outcomes should be monitored at company level and, if not up to standard, discussed with the authorities.

- *Involve job centres at an earlier moment.* According to the current rules, the municipal job centre gets involved in the process after around eight weeks of absence. This is too late for many workers absent with a mental illness and/or a workplace problem. Indicators should be developed to identify illnesses or groups of absentees able to benefit from earlier intervention. Companies should have the possibility to request early intervention by the responsible job centre. After eight weeks job centre caseworkers need to get involved forcefully and systematically for the large majority of those still on sickness benefit. The job centre should also be responsible for monitoring employer intervention.

- *Involve doctors more systematically*. Doctors are often key players in the return-to-work process and since recently, they can also be reimbursed for attending return-to-work meetings with the employer and the job centre. Such meetings should be organised more regularly, especially for cases involving a certified or somatised mental disorder or a workplace conflict. Guidelines and training for doctors are needed on how to use the workability record (which since recently supplements the sick note). The job-retention-oriented use of the workability record should be monitored and evaluated.

- *Investigate how a gradual return to work could be realised.* More research is needed to better understand why a gradual return to work with a partial or gradually-reduced sickness benefit has apparently not helped those absent with a mental disorder (while it has been shown to be quite effective for other groups of sick workers). Once more is known about the obstacles for this approach being more helpful for this group, steps should be taken accordingly. For instance, for those mental illnesses for which sickness absence itself is counterproductive, return-to-work action needs to come earlier.

Notes

1. Rugulies *et al.* (2006), for example, found that women with low influence at work (relative risk RR=2.17) and low supervisor support (RR=2.03) were at increased risk of severe depressive symptoms; while among men job insecurity (RR=2.04) predicted severe depression. Wieclaw *et al.* (2008) found that low job control (RR=1.40) and job strain (R=1.13) increased the risk of anxiety disorders in men while high emotional demands (RR=1.39) and high overall job demands (RR=1.20) elevated the risk of depression in women. Munir *et al.* (2010) concluded that the quality of leadership was associated with reduced sickness absence for workers with moderate depressive symptoms (not those with severe symptoms).

2. Following market liberalisation of a mandatory system prior to 2002, today there is a fully competitive market with some 150 working environment consultancy companies operating throughout Denmark.

3. For more information on these guidelines, see www.tidlig-aktiv-indsats.dk/PWEarlyActiveEffort.aspx?lang=da&mi=3&itmimain=3&itmi=31.

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Chapter 4

Sickness, unemployment and return to work in Denmark

This chapter discusses how the municipal job centres, the main stakeholder in Danish welfare and employment policy, cater for persons with mental health problems. It looks successively at the main issues for the key client groups – unemployment, sickness and social assistance beneficiaries – with particular focus on the identification of mental illness as a labour market obstacle. It also addresses the implications of two major reforms affecting job centres and their clients with mental disorders: recent reform of the very generous system of subsidised flexjobs, and the upcoming reform of the reimbursement of municipalities by the central government for the benefits they provide.

Denmark has a unique system setup offering great opportunities for providing "the right employment support to the right people at the right time" – a key policy success factor according to OECD (2010). One local authority, the municipal job centre, is responsible for all people seeking to stay in or return to employment, irrespective of the type of benefit they receive, their insurance and employment status and their distance to the labour market. Everyone can get access to any of the measures and active labour market programmes (ALMPs) available at the job centre, whenever a need for such measure is identified.[1]

The potential of this strong setup is only partially harvested, however, especially when it comes to people with a mental disorder. First, the strong mainstreaming focus runs the risk of people's extra needs, and health needs in particular, remaining unaddressed. Secondly, there are large differences across municipalities in what is being done, when, and for whom. Finally, job-search and availability requirements for the unemployed are comparatively tight in principle, but Denmark could improve in terms of job-search monitoring (Venn, 2012). This would be particularly important for jobseekers with a mental health problem.

No identification of jobseekers with mental illness

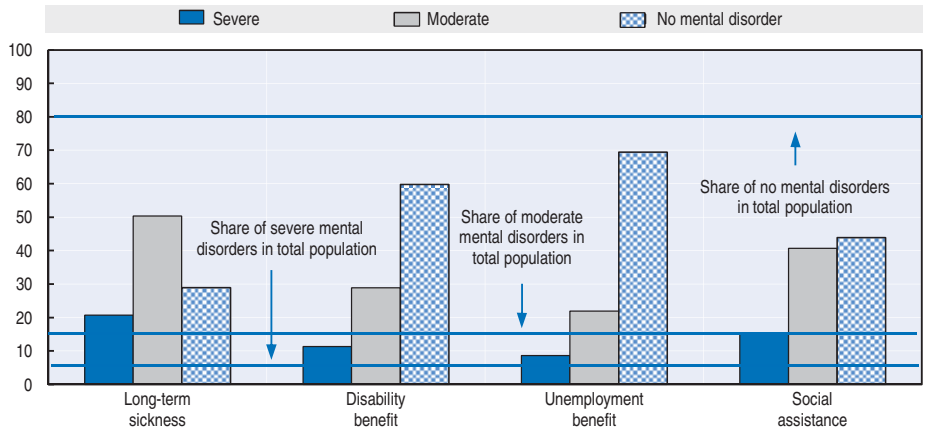
There are no administrative data available in Denmark on the mental health status of the population serviced by the job centres because health information is not collected nor recorded in a systematic manner. It is up to, and in the hands of, the municipal caseworker to identify additional problems of a client impeding his/her employment chances, or to seek support for identifying a potential mental health problem. There are no guidelines or instructions for caseworkers on how to do this. Caseworkers – who cannot make any diagnosis themselves – largely rely on the information provided or revealed by the client. Each job centre has a medical consultant and/or a psychologist who the caseworker can consult, if needed.

The caseworker can also choose to send the client to a general practitioner or a psychiatrist; in such a situation seeing a doctor for a clarifying medical assessment is compulsory in principle (*i.e.* if the client refuses, the benefit payment can be withdrawn). The same holds for a situation in which a client refuses medication prescribed by a doctor – noting that a caseworker would seek regular follow-up of a person in treatment, including regular contact with the doctor to find out when a person is work-ready. In practice, however, benefit sanctions in relation to (mental) health matters would be rare and no information is available on the share of clients sent to a medical assessment or the number of cases in which the caseworker would be in contact with a doctor.

The lack of a more systematic approach to identifying and recording mental health problems is unfortunate in view of the very large share of job centre clients facing a mental disorder. According to the Danish Health Interview Survey, around 60% of all social assistance clients (many of who have been out of the labour market for a very long time) and over 70% of those on long-term sickness benefit have a mental disorder – compared to only 20% in the general working-age population (Figure 4.1). The corresponding share is around 40% for disability benefit and still almost one-third for unemployment benefit recipients. Figure 4.2 further shows that mental ill-health prevalence is proportional to the duration of unemployment: those with a mental disorder are overrepresented in all groups of the unemployed but most among those who report they have been unemployed for at least 2.5 years in the past three years.

Figure 4.1. **The majority of recipients of social assistance and long-term sickness benefits have a mental disorder**

Proportion of beneficiaries with severe, moderate and no mental disorder, by type of working-age benefit, 2005

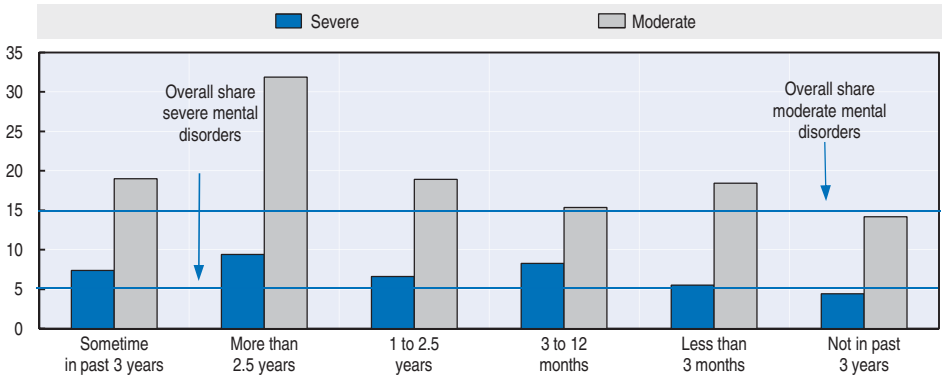


Source: Danish Health Interview Survey (SUSY) 2005.

Unpublished municipal evidence corroborates these findings and suggests that many job centres are aware of the mental health challenges many of their clients are facing. According to the staff from one of the biggest job centres in the country (in Roskilde), the share of clients with mental health problems varies from less than one-third among the insured unemployed to over 40% among sickness benefit clients (short and long-term together) and over 50% among those in the harder-to-place groups (*e.g.* young people and those likely to apply for a disability benefit).

Figure 4.2. **People with a mental disorder are highly overrepresented among the unemployed, especially the long-term unemployed**

Proportion of unemployment beneficiaries with severe, moderate and no mental disorder, by duration of unemployment, 2005



Source: Danish Health Interview Survey (SUSY) 2005.

Despite this awareness, there is no discussion currently in Denmark on introducing better means to identify mental disorders in jobseekers. This is unfortunate as research has demonstrated there are good, valid and easy-to-use screening instruments available to identify common mental disorders in the working-age population generally (*e.g.* Andrea *et al.*, 2004), in general practice (*e.g.* Christensen *et al.*, 2005) or, more specifically, for those on long-term sickness absence (Søgaard and Bech, 2009). The use of such tools by the job centre caseworker, for example, could be useful because information about (hidden) mental disorders in jobseekers is of relevance for the choice of the rehabilitation measure and the return-to-work strategy.[2]

Not having a screening of a client's mental health status implies a lack of systematic measurement of the client's needs and employment barriers caused by mental ill-health. There is only one group of clients for whom the job centre caseworker has more systematic information on health and workability: those receiving a sickness benefit have to have a workability record supplied by their doctor. If the workability record is incomplete or insufficient to assess the client's work readiness, it is possible to seek a second opinion from another doctor.[3]

With so many job centre clients suffering from a mental disorder, the ability of the caseworker to identify mental health issues is critical. It is the caseworker who decides what information to give to a client and what course to offer. But the knowledge of caseworkers about mental disorders is poor – and many caseworkers will mistakenly believe it is better for the

client to stay at home, especially for those on sickness benefit. There is no nationwide approach to empowering caseworkers to help clients with a mental disorder. Guides for caseworkers have been prepared on how to identify a mental disorder, which emphasise how good work is for such a client. Voluntary training courses are being offered by two psychiatrists, with the demand for these courses being much higher than the supply.

These efforts fall short of the actual needs of the municipal job centres in terms of mental health competency, to be better able than today to identify needs caused by mental ill-health and to offer solutions which integrate treatment aspects with employment supports. The use of a screening instrument to detect mental health-related employment barriers would be a big step ahead. Resulting information should be used as a means to provide the best-possible services. Confidentiality and privacy concerns would have to be satisfied and could be solved by seeking the agreement of the client. There is no need to share the information with potential employers.

Weaknesses in the financial stimulus model

Another more general issue in the Danish employment and benefit system is the differential reimbursement rates from the state budget to the municipality, varying with the type of benefit or intervention a person receives. The main idea behind this innovative stimulus scheme is to provide incentives to the municipality to *i)* offer measures that help the person return to the labour market and *ii)* prevent long-term benefit payments. Accordingly, the state reimburses 65% of the costs of rehabilitation and flexjob subsidies, for example, but only 35% of the disability benefit costs, 30% of the costs for social assistance and unemployment exceeding eight weeks, and none of the costs of sickness benefit payments exceeding one year (Table 4.1).

The system has seen a series of changes in the past decade characterised by a gradual reduction in reimbursement rates for various passive benefit payments from 65% or 100% to 35%, if not 0%.[4] A second main feature of change is a much increased differentiation of the reimbursement rates, with the aim being to stimulate the right action. Accordingly, reimbursement rates are set to 0% whenever insufficient documentation is provided (flexjob subsidy) or active measures are unduly delayed (unemployment, social assistance) or benefit payment has reached an exceedingly long duration (sickness benefit, unemployment benefit and waiting allowance).

While this stimulus scheme has significant potential in so far as it tries to tackle directly the incentives of the employment service and benefit authority (the Danish job centres) – a key issue poorly addressed in most other OECD countries (OECD, 2010) – it was shown to give room for

"tactical" behaviour. For example, municipalities could be inclined to park people on sickness benefit for a year, only moving them onto a flexjob once sickness payment is becoming costly to the municipality. The recent changes aimed to minimise such behaviour.

Table 4.1. **Some interventions seem very "attractive" to the municipality**

Rate of state-funded cost reimbursement to the municipality, by type of intervention

Type of intervention or benefit	Percentage of cost reimbursed to the municipality					
	0%	30%	35%	50%	65%	100%
Disability benefit[a]			x			
Unemployment benefit[b], week 0-8						x
Unemployment benefit, after week 8		x				
Unemployment benefit, after week 8, active measures[c]		x		x		
Unemployment benefit, after week 8, undue delay in active measure	x					
Social assistance benefit		x				
Social assistance benefit, active measure[c]		x		x		
Social assistance benefit, undue delay in active measure	x					
Early-retirement pension[b]	x					
Sickness benefit, week 0-4						x
Sickness benefit, week 5-8				x		
Sickness benefit, week 9-52		x				
Sickness benefit, week 9-52, active measure[c]		x		x		
Sickness benefit, after weeek 52	x					
Flexjob subsidy, sufficient documentation					x	
Flexjob subsidy, insufficient documentation	x					
Waiting allowance, less than 18 months		x				
Waiting allowance, less than 18 months, active measures		x		x		
Waiting allowance, after 18 months	x					
Pre-rehabilitation		x		x		
Rehabilitation		x		x	x	

a. Since 1999 the municipalities' costs of all new disability benefits are reimbursed at 35%. A planned reduction to only 20% reimbursement did not go through.

b. Eligibility for unemployment benefit and the early retirement pension is dependent on membership in an unemployment insurance fund. These benefits are paid out from these funds, but the municipalities co-finance the costs of the unemployment benefits.

c. The municipalities' reimbursement rate during active measures depends on the type of the activity – formal educational activities and non-formal or other activities.

Source: Data provided by the National Labour Market Authority.

There is no information available on the impact of the stimulus scheme and the municipalities' behaviour on different groups of clients including clients with a mental disorder. Presumably, more disadvantaged clients and those with complex mental health and social problems are more likely to be

parked for a certain period (parked on the waiting allowance, for example, given that this number has increased sharply in the past few years and continues to increase) while also being those suffering most from being away from the labour market for too long. There is a great risk that the municipal reaction to the differentiated reimbursement schedule is driven by short rather than long-term considerations. This is aggravated by the fact that indicators to monitor municipal effort are still process-oriented (mainly because such information is easier to collect), rather than focussing mainly on long-term employment outcomes.

Discussions have started on further and, this time, more structural changes to the reimbursement schedule. The suggestion under discussion currently is to replace the differentiation by type of benefit with a differentiation by the *duration* a client has been in the system: starting with a higher rate initially, maybe 50% or 75%, with no differentiation by type of benefit, and gradually falling over time to 0% for every client who has been in the system for, say, three years. This would do away with the incentives to "play" the system and make it attractive for the municipality to act swiftly – a win-win given that the return-to-work chances fall very quickly with the duration out of work.[5]

Performance monitoring to improve municipal action

Job centres have great freedom and independence even though they work towards national employment policy goals and under the supervision of a regional labour market authority. The municipal independence opens room for innovation and interesting practices. With the recent move towards stronger and more systematic monitoring and benchmarking of outcomes, there are greater opportunities today to harvest the potential of this setup *i.e.* opportunities for poorer-performing job centres to learn from the good practices of better performers.

The work of job centres is recently measured more stringently, with a comprehensive benchmarking tool that monitors the use of programmes for different clients (Jobindsats) and another newer tool (still under development) that measures the cost-effectiveness of these programmes (*Effektivindsats*). Jobindsats data are available online to everyone and allow comparisons by municipality, job centre or employment region. Data are still process-driven but outcome-based data could easily be integrated into the benchmarking, at least in theory.

The regional labour market authority (RLMA) has both a control and an advisory role. There are annual meetings of the RLMA with every job centre to go through success and failures and spread good practices from other job centres. The RLMA uses formal and informal tools. The formal tools include a dialogue based on the national targets set by the employment ministry (targets

which often run over several years and are to be implemented by the municipal authorities); a strategy plan; and a revision of results. The informal tools include frequent dialogue on special projects, up to ten times a year.

The policing role gives the RLMA status and legitimacy vis-à-vis the job centres. If a job centre fails to achieve the agreed targets, the RLMA will seek more intense "dialogue" and more frequent meetings. But there are no sanctions (although in theory in case of very poor performance the RLMA could outsource employment services to a private provider). Benchmarking and "naming and shaming" are considered more appropriate and administratively more efficient than sanctions. The main aim of the targets and dialogue is to achieve progress.

The RLMA also acts as a facilitator of good-practice dissemination (to go beyond transparency and information sharing) and aims to understand what works for whom – with increasing focus on evidence-based methods via randomised controlled trials. It also has funding available to develop new approaches. In view of the limited resources (there is roughly one RLMA staff member for each job centre), the RLMA should focus on smaller municipalities which need the support and expertise.

With no information being collected on mental health problems of job centre clients (or in fact health problems more generally), none of the targets or monitoring mechanisms target mental disorders. Additional municipal targets with regard to jobseekers with a mental disorder, however, would be possible – and could lead to a more systematic and transparent approach for this group. Sufficiently accurate instruments which enable the early detection of mental health issues are available.

Matching clients to the right activation strategy and service

In line with the Danish flexicurity approach, activation is done in two phases. Before being helped with all kinds of ALMPs, people are supposed to help themselves for a considerable period – usually nine months but shorter for certain risk groups, such as young jobseekers for example. The idea behind this is, first, to ensure sufficient search time to prevent rapid de-qualification by forcing people to accept too quickly a lower-qualified job and, second, to focus resources on those with the greatest needs.

Assigning clients to different match groups

The Danish job centres use a simple matching tool at intake, distributing clients across three match groups and reassessing (and regrouping) them every third month:

- Match group 1 includes those who are assessed as being job-ready *i.e.* all those registered as unemployed (the insured unemployed) and those on sickness benefit and able to work within three months.
- Match group 2 includes those not directly job-ready but with a good chance to move back into employment; basically all other sickness benefit clients, those on rehabilitation or pre-rehabilitation benefit and most of those on social assistance.
- Match group 3 is those who need substantial support (*e.g.* in the form of treatment or hospitalisation) and are assessed as being unlikely to move back to work (*e.g.* clients at the brink of moving onto disability benefit).
- Those on disability benefit already are considered unable to work and are, therefore, no longer clients of the job centre.

In principle, match group 1 is followed up every three months and match group 2 every four weeks whereas the approach for match group 3 is more passive. Caseloads also differ across the groups, ranging from 40-50 per caseworker for sickness benefit receivers in match group 2 to about 80 for the non-insured unemployed on social assistance as well as those on rehabilitation benefit to several hundred for those in match group 1. The lower caseload for sickness benefit clients reflects the recent priority given to this clientele.[6]

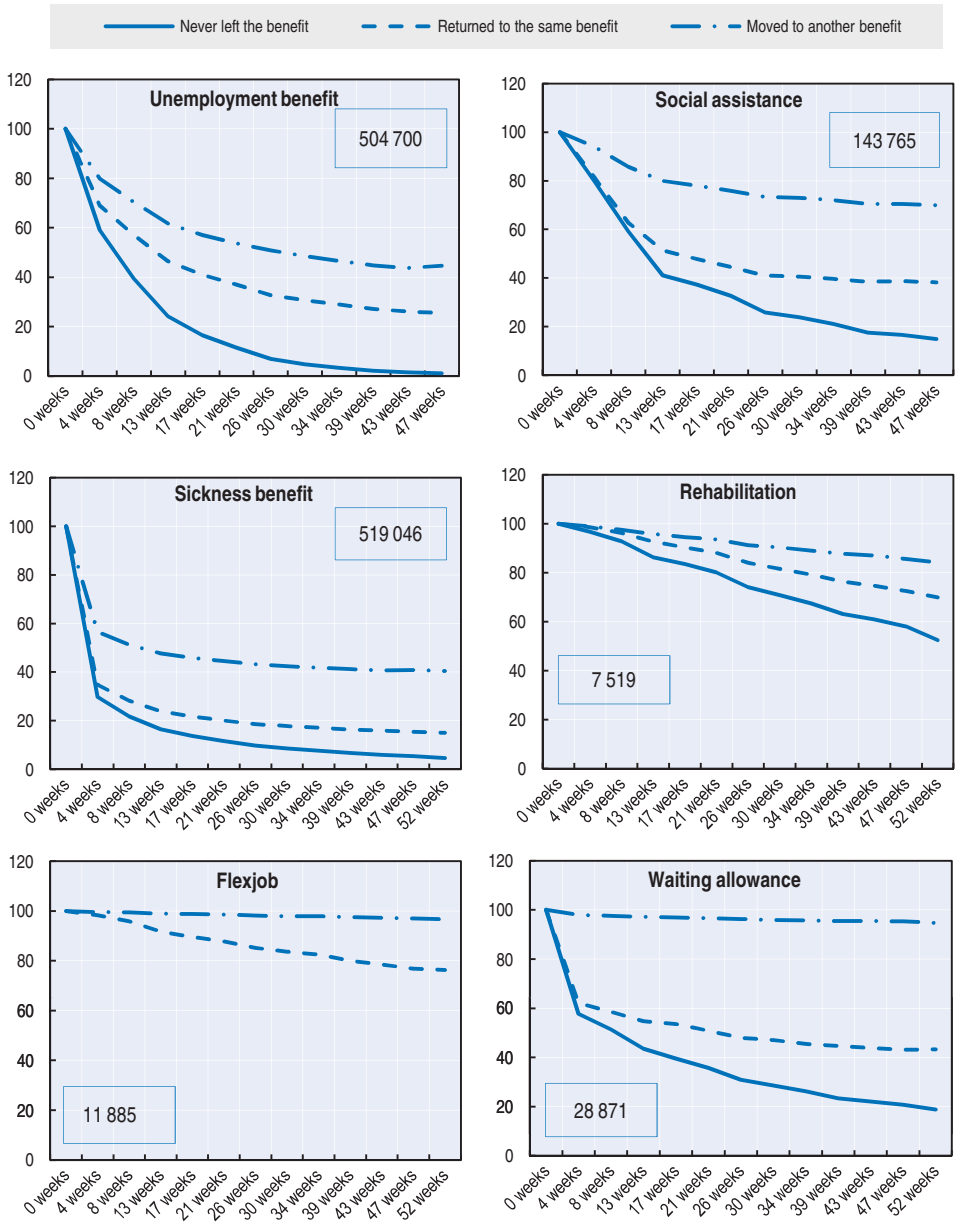
Accordingly, the majority of those in match group 2 will be people who – often in addition to a range of other employment barriers – suffer from a mental illness. The lower caseload for this group will help but it will not allow the caseworker to spend sufficient time with those with multiple needs. For this, a caseload around or even below 20 would be needed – as is the case for some of the most successful providers in Denmark specialised in supporting jobseekers with a mental illness (see below). Such low caseload will be hard to implement widely in the current economic climate.

No data is available on the fate of different match groups but information on the persistence and reoccurrence of different benefits is readily obtainable. People stay on benefits for a considerable period. The largest outflow is found for unemployment and sickness benefit, benefits with very large recipiency numbers (Figure 4.3).[7]

However, while only one in 20 sickness benefit recipients stay on the same benefit for a whole year, many more move back onto sickness benefit a second or third time within a year, and as many as 40% move onto some other benefit. The situation is similar for unemployment benefit although the outflow is more gradual over time. For sickness benefit, there is little additional outflow once people have been on benefit for 13 weeks or so.

Figure 4.3. **People stay on working-age benefits for a very long time**

Survival probabilities in the first year on different benefits in Denmark, 2010



Note: The figures in the panels refer to the yearly average number of recipients of each benefit.

Source: OECD calculations based on the Jobindsats Database.

This three-month time limit also appears to be critical for social assistance benefit recipients: people move either off such benefit rather quickly or they do not; and around 70% are on one or the other working-age benefit a year later. This proportion is even higher for those receiving a waiting allowance (95%) or a rehabilitation benefit (85%) – two benefits that by and large function as transitional payments towards a *de facto* permanent flexjob subsidy or disability benefit

Again, lacking measurement of the mental ill-health-related barriers to employment implies that it is not possible to compare the benefit persistence and reoccurrence rates of clients with and without a mental disorder. Data for other countries such as Sweden suggest that the attrition from a public benefit is significantly delayed for recipients with a mental disorder (OECD, 2013). In the following, the approach of the Danish job centres for clients in general, and those with a mental disorder in particular, is discussed, distinguishing the three main benefit categories: unemployment benefit, sickness benefit and social assistance clients.

Unemployment benefit clients

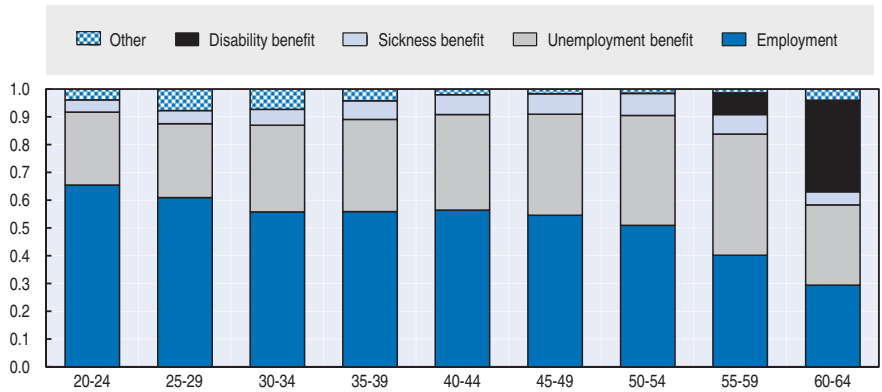
Generally for the (insured) unemployed in match group 1, nothing really happens during the first few months – unless the jobseeker is under age 30 (Chapter 2) or over age 60. In all other cases, activation will only kick in after around nine months. During the first period, the jobseeker will be in touch with an administrator from the unemployment insurance fund to which he is enrolled who will check benefit eligibility and job-readiness, but rarely would there be any contact in the first six months with a job centre caseworker who would receive basic information about job-search via the unemployment fund (note that the benefit is also paid to the insured by the fund).

This approach is justified and efficient to a certain degree: One in two unemployed will be back in employment six months later, the proportion being highest for workers under age 30 and significantly lower for those over age 55. Another 30-40% will still be unemployed at this time, but many of those will move back into employment at some point as well. Of the remainder, the largest share moves onto sickness benefit. Only in the age groups 60-64 and 55-59 is a transition from unemployment to disability – at 33% and 8% of the age group, respectively – also common (Figure 4.4).

The unemployment funds have no responsibility for and little interest in a return to work by the jobseeker. Municipalities through their job centres are free to do more for this group, if they wish and their resources allow. With the recently introduced unemployment benefit cost-sharing, earlier action has become more appealing for the municipalities; however, little has happened in this regard so far.

Figure 4.4. **Most unemployed are back in work six months later**

Distribution of beneficiaries six months after ending an unemployment period, 2010



Source: OECD calculations based on the Jobindsats Database.

The structure of the activation regime is likely to pose problems for people with a moderate mental disorder who are in match group 1 (potentially up to one-third of this group): for these jobseekers, activation only kicks in after a nine-month "self-service" period. Unsuccessful job search during this period could easily pass unnoticed with activation coming much too late for those unable to help themselves. With the rather flexible Danish labour market, they may be able to find jobs but they are far more likely than others to lose their job again very quickly and to oscillate between employment and unemployment.

The strong focus on helping yourself during a fairly long period is questionable in view of research findings, also for Denmark, suggesting that tighter monitoring of the unemployed reduces the unemployment duration. Using Danish event history data, van den Berg *et al.* (2012), for example, find that the transition rate back into employment strongly increases after meeting the job centre caseworker – with the effect size persisting for some weeks after the meeting and increasing with the number of meetings.

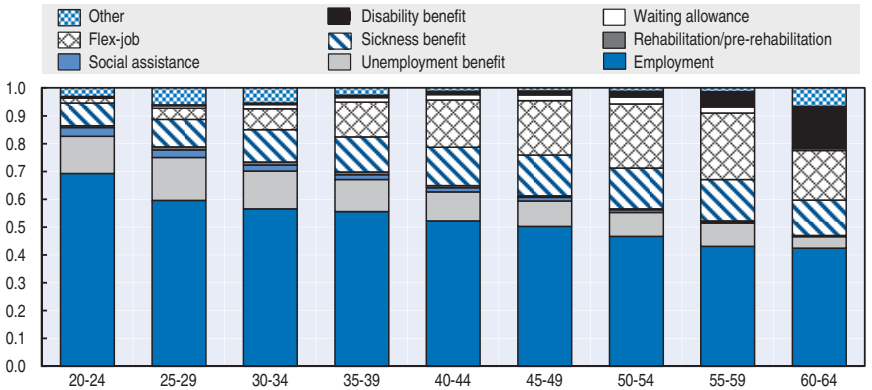
Sickness benefit clients

Most medium-term sickness benefit clients will be in match group 2 with more support resources and a more stringent activation regime – and the majority of them struggling with mental health problems. Some 40-70% of these clients, depending on age, return to work, *i.e.* to their previous job or employer, within six months (Figure 4.5). A significant share, however, only returns to the labour market through a subsidised flexjob – recognising that they have more permanent partial work-capacity restrictions (see further below for more details on flexjobs); this share increases to around 25% in

the age group 50-59. Also in this group, however, probably the majority will have returned to their previous employer but with a flexjob subsidy. No information is available on how this destination distribution varies with mental health status.

Figure 4.5. **The older a sickness beneficiary, the less likely is a return to work**

Distribution of beneficiaries six months after ending a sickness period, 2010



Source: OECD calculations based on the Jobindsats Database.

Through the regularly updated workability records, the caseworker in this case is more likely to become aware of a client's mental health problem, especially if identified and diagnosed, with a better chance of addressing the underlying issues. Even so, undetected secondary mental health issues co-existing with a somatic disorder will be frequent in this group as well.

A critical issue for sickness benefit clients is whether or not their work contract is still valid, such that intervention can focus on a return to the job or the employer, possibly with a flexjob subsidy. Today, however, more and more people are sick-listed from unemployment, due to the crisis and the lenient dismissal regulations; in fact often workers are fired because employers have no idea how fast the worker could possibly return to work – reiterating the need for the municipal job centre to get involved earlier, not only after eight weeks.

Return-to-work interventions for clients with a mental health problem could include mainstream measures, like on-the-job training (possibly also with the own or previous employer), temporary wage subsidies and education measures, but also more health-targeted measures including cognitive behavioural therapy and similar therapy sessions with a psychologist. The degree to which such health interventions occur is unknown and will depend on the job centre as well as the caseworker. The high share of those with a mental disorder in the group of long-term sickness

benefit clients (Figure 4.1), however, suggests this is not done enough and/or not effectively.

Some jobseekers with mental health problems – problems that go beyond the capacity of the job centre – will be offered special services which the job centres would usually purchase from specialist providers. One such scheme with relatively good outcomes is run by the Psychiatry Fund (which is contracted by most job centres) and targets adults who have been on long-term sick leave for at least six months due to a mental illness. The two main success factors of this intervention are, first, the very low caseload and, secondly, the use of psychologists as specialist caseworkers (Box 4.1).

Box 4.1. **A successful return-to-work intervention by the Psychiatry Fund for the long-term sick with a common mental disorder**

The return-to-work programme of the Psychiatry Fund (a non-profit organisation founded in 1996) targets clients with a common mental disorder with a considerable labour market career who have been on sick leave for at least six months (practically often over one year). Intervention is *voluntary* because motivation is deemed essential, and clients need to be ready to be helped; this will be determined in a pre-meeting with the job centre (all referrals are coming from the job centre; clients not ready will be refused).

The structured intervention combines education on the client's illness with tackling of workplace issues and short-term treatment through cognitive behavioural therapy. After initial clarification, the intervention would typically last 19 weeks: six weeks of (group) courses to help understand the illness and teach coping mechanisms, followed by 13 weeks of trial employment or apprenticeships of a few hours per week.

Basically, this intervention is specialised job centre casework with a particularly low caseload (of around 10) and run by people specialised in working with clients with a common mental disorder. Most of the counsellors are psychologists who talk to clients as life coaches, not therapists. The focus of the counsellor who has weekly one-to-one meetings with the client is on education and employment, not the client's personality; talking about returning to work (often to a new workplace), psychological counselling and helping to access mental health treatment are key aspects during these meetings.

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

Social assistance clients

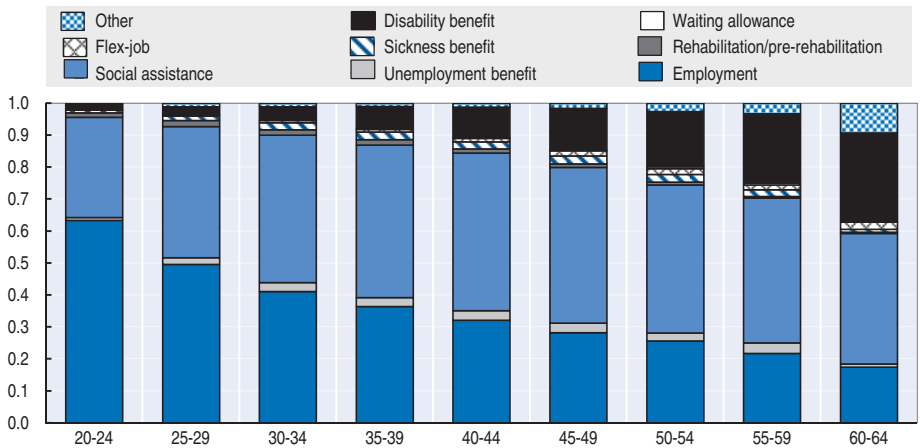
The third large target group of the job centres are those receiving social assistance – *i.e.* non-insured unemployed and those long-term unemployed

who exhausted their unemployment benefit entitlement. Today, two-thirds of these clients are in match group 2 with the tightest follow-up – a big change from about a decade ago when very little was done for those clients (very much like for match group 3 today).

It is important to help social assistance clients for several reasons: *i)* numbers are increasing recently and will increase further because of the forthcoming reduction in the unemployment benefit duration from four to two years; *ii)* some clients stay on social assistance for a very long time; *iii)* many of them have complex problems including health and in particular mental health problems; and *iv)* social assistance has become a major route into disability benefit – as shown in Figure 4.6. Put differently, some of those not making it onto disability benefit get stuck on social assistance for an interim period and will often end up on disability benefit sooner or later.

Figure 4.6. **Social assistance has become a major route into disability benefit**

Distribution of beneficiaries six months after ending a social assistance period, 2010



Source: OECD calculations based on the Jobindsats Database.

Again, mainstreaming implies that the approach for social assistance clients is not necessarily different from that for other clients. However, for this group overall work trials in a real workplace have shown better outcomes than other measures, also better than the previously used community employment. Clients can be on such programme for up to two years while still receiving social assistance benefits. There is a special contact person in the job centre to follow up and address all problems arising. Employers can have up to four such people at the same time (which strongly facilitates finding places for these clients) and they report that they

are very satisfied with the contact person who is holding weekly meetings with the employer and the employee. Around 20% of those going through this programme can self-sustain themselves afterwards.

The focus on real work trials with intense follow up and contact with the employer is also most promising for the large sub-group of social assistance clients who struggle with mental health problems.

Generous wage subsidies for people with partial work capacity

One of Denmark's most innovative ALMPs is its *flexjob scheme*, a generous wage subsidy scheme targeted at people with reduced work capacity unable to work in the regular labour market but not incapacitated enough to be entitled to a disability benefit. The flexjob system (which was introduced over ten years ago and given more weight in the course of the 2003 disability benefit reform) has great potential for those with a common mental disorder because it allows for both fewer working hours and lower productivity at full hours – with full pay for the worker but only effective output to be paid by the employer.

However, the system was *not* created for people with a mental disorder and formally only some 15% of all flexjob users are registered with a mental illness. Nonetheless, given the large flow from sickness benefit onto flexjobs, most likely a large share of flexjob users will have a (typically undiagnosed) common mental disorder. Survey data suggest that, among persons with disability more narrowly defined, those with a mental disability are, if employed, more likely to be employed on special conditions, *i.e.* on either a flexjob or other forms of subsidised employment: the share is 35% for those with a mental disability compared with 24% for those with mobility limitations and 18% for those with other disabilities (Thomsen and Høgelund, 2011).

The flexjob scheme has never achieved its objectives. Because of its generosity (with a subsidy level that increases with the wage and has a high upper ceiling of almost twice the average wage and, thus, twice the level of a disability benefit), it has attracted an fast increasing number of people over time (Figure 1.2) without any corresponding reduction in the number of disability benefit recipients. The system seems to be reaching the wrong people: it incites many of those who would have worked in the regular labour market without a subsidy to apply for a less demanding job, rather than those with a partial work capacity who should not be receiving a permanent disability benefit (OECD, 2008).

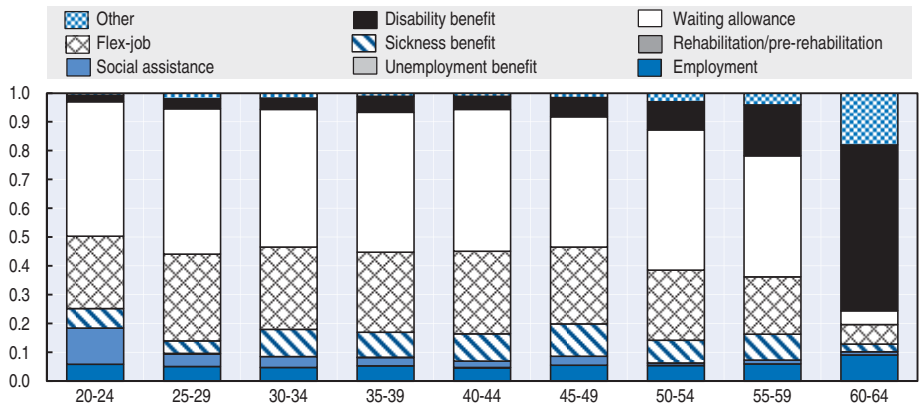
Other unsatisfactory outcomes include the gradual shift towards a higher subsidy;[8] the high share (around 50%) of flexjobs with one's own employer,

due to the possibility to transform an existing job into a flexjob; the dominance of public municipal flexjobs; and the frequent move to a flexjob (often a municipal one in these circumstances) after expiration of a sickness benefit entitlement. It was far too easy to qualify for a flexjob partly because of insufficient documentation requirements until recently (but over the years requirements have been tightened and the rate of state reimbursement for poorly documented cases has been reduced significantly).

Figure 4.7 further shows that those who end a flexjob almost never return to unsubsidised employment or a regular job: people would either stay on a flexjob for a long time; or, even more frequently, lose their flexjob at some point and move onto a waiting allowance *i.e.* a benefit paid at the level of a disability benefit for people waiting to be placed into a (new) flexjob; or move onto a disability benefit, especially if over age 55. In principle, this is in line with the original idea of a flexjob which is designed for people with *partial* but *permanent* reduced work capacity. The dead-end character of flexjobs has turned into a big financial problem, however, exactly because the system has spread so fast to include many people who used to work in unsubsidised jobs. The permanent nature of flexjobs also ignores the fact that people's work capacity will often improve and that many mental illnesses in particular will get better over time.

Figure 4.7. **Very few people return from a flexjob to the regular labour market**

Distribution of beneficiaries six months after ending a flexjob period, 2010



Source: OECD calculations based on the Jobindsats Database.

Will the forthcoming reform of the flexjob scheme deliver?

In recognition of the above weaknesses, a major reform has been settled in agreement with all political parties, which is likely to come in force in

early 2013. In short, the aim is to eliminate the major flaws while maintaining the basic thrust and the potential of the system.

The reform aims at *i)* better targeting of the scheme to persons with lower work capacity; *ii)* improved incentives for employers to newly hire people on a flexjob, if only for a few hours; and *iii*) better incentives for those developing their employability while working in a flexjob to increase the number of working hours and, eventually, to move off the subsidised flexjob (Box 4.2).

Box 4.2. **A comprehensive reform of the Danish flexjob scheme**

Recognising the failures and weaknesses of the flexjob scheme, the government has announced a far-reaching reform with the following features:

- In the future, the employer and the employee will have to agree on the *effective* hours worked (the productive hours; actual working hours can be longer), with the employer paying a wage corresponding to those hours and the municipality paying a subsidy to the employee (previously the employer) to cover the remaining hours. The two existing flexjob options (half and two-thirds of work incapacity loss) will be replaced by a gradual system allowing any weekly working hours (between one and 39 hours per week). The job centre will have to approve the arrangement; and the agreed hours and the corresponding subsidy level will or can be adjusted every year.
- To address the generosity issues, the maximum flexjob subsidy will be reduced to 98% of the maximum unemployment benefit, to be deducted from the actual wage hour-by-hour; the taper rate for additional earnings is 30% up to an earned income of DKK 13 000 per year and 55% for earnings above this threshold. As a result, actual income will increase with working hours (while today everyone receives a full wage) and the difference with a theoretical full wage is largest for those with higher earnings (not so today). Put differently, those with the lowest wage will get the largest subsidy.
- On top of this, flexjobs will only be granted *temporarily*, initially for five years, with proper reassessment (with a focus on mental ill-health); those receiving a flexjob will become eligible for registering with an unemployment insurance fund; and there will be more activation for those registered as unemployed and referred to a flexjob or waiting allowance (*i.e.* more reintegration effort before a flexjob is granted). The temporary focus of flexjobs will be strongest for young people: the aim being to move them back into regular jobs.
- Nothing will change for those on a flexjob already (as long as they stay on the same flexjob); the new regulations will apply to all those moving into a new flexjob, including via waiting allowance or a previous flexjob. The waiting allowance itself also remains largely unchanged (and will remain permanent).

It was estimated that the flexjob reform, together with the reform of the disability benefit system, will result in savings of around DKK 1.9 million in 2020 and around DKK 3.5 million annually in the long term. It is expected that the number of flexjobs will remain largely the same, or in fact increase, especially among the young, but with a shift in severity of those entitled: in the future more of those currently moving onto disability benefit should move into a flexjob, and more of those with considerable capacity who are now moving onto a flexjob should stay in regular employment.

Whether all this is going to happen remains to be seen; the reform addresses many of the weaknesses of the current system and removes much of the highly inefficient generosity. However, some flaws remain, at least partially. Most importantly, it will remain difficult to reach the right group of people because it will remain attractive for employers to turn existing work contracts into flexjobs. It is also problematic to grant "temporary" subsidies initially for long as five years; this will be felt close to permanent by those involved, and municipal caseworkers will find it difficult to remove existing entitlements. Therefore it is unlikely that the reform will succeed in transforming temporary flexjobs into regular jobs.

Are flexjobs the right approach for those with a mental disorder?

Very little is known about the use of flexjobs by those with a mental disorder and there is also no discussion about the impact of the system and the reform for this particular group. The age structure of flexjob users is telling in this regard: in contrast to most other working-age benefits, the large majority of flexjob users are in the age group 45 and over; young people under age 30 are rarely ever granted a flexjob (Figure 4.8).

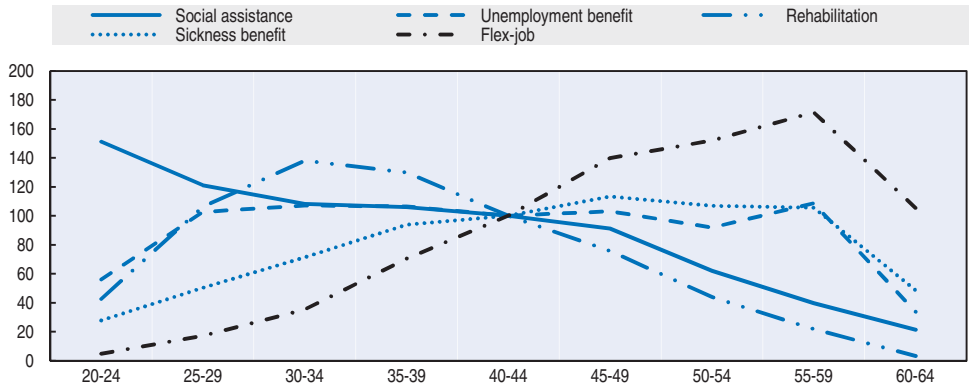
This is good insofar as the current system is geared towards permanently reduced work capacity and, therefore, less adequate for both young people and those with a mental disorder; and young people with a mental illness in particular. However, the number of young people moving onto disability benefit has increased substantially – and for many of those, a flexjob would have been a far better solution.

Many of the planned changes to the flexjob scheme will probably be especially helpful for clients with a mental disorder who are among the most disadvantaged (and therefore benefitting least from the current regulations). Moving to a system that is temporary in principle, far more flexible in terms of hours and changes over time, and has a stronger focus on activating and reintegrating those (potentially) eligible for a flexjob could benefit those with a mental disorder significantly. A shift towards better use of collective agreements to tackle work capacity issues, however, unless supported by

psychological and vocational expertise for example from the municipal job centre, could well pose a problem for those with a mental disorder, in view of the fears and stigma around these illnesses.

Figure 4.8. **Flexjob users in Denmark are typically much older than those on unemployment, sickness and social assistance benefits**

Age distribution of recipients of various working-age benefits, index (age group 40-44 = 100)



Source: OECD calculations based on the Jobindsats Database.

In any case, change will have to be implemented rigorously and the target group of flexjob users will have to be redirected very actively, in order to turn the system from a scheme that supports the permanent exit of older workers from the regular labour market into a transient support system for people of all ages with significant but not permanent work incapacity constraints, many of which caused by a mental disorder.

Conclusions and recommendations

Denmark's municipal one-stop job centres for all jobseekers as well as those seeking support for job retention provide a unique opportunity to service people in the best possible way. However, much more could be done to reap the opportunities this unique setup provides. The mainstreaming approach used by the municipal job centres allows access to all kinds of measures for all types of clients, but clients with complex disadvantages and those with a mental disorder will have great difficulties in benefitting from this "free" access to all services.

This is unfortunate in view of the likely large share of the job centre clientele suffering from mental health problems. The absence of mental health screening and the sole reliance on caseworkers in this regard implies

that some of the barriers to finding suitable employment will remain unaddressed – and none of the new developments, including the much better performance monitoring of the municipal job centres and the forthcoming remodelling of the cost reimbursement to municipalities, will be able to address or measure this.

Much is known about what intervention works best for which groups of clients, and even though mental health status is not part of the analysis and data collection in most cases, quite a few inferences can be drawn on what works best and what needs to be done for those with a mental disorder. Key success factors include involving the employer quickly as long as the client has an employment contract; meeting the caseworker quickly and regularly; investing in low caseloads and psychological training for caseworkers; moving to support that is flexible and adjustable; and providing opportunities for work trials in a real-work setting with continuous contact with the job centre. These elements will have to be expanded.

Seek to identify mental health problems of job centre clients

- *Use screening tools systematically where indicated.* Mainstreaming of employment policies leads to much better results if additional barriers to employment are also addressed. Mental health problems are among the most frequent such barriers which, if hidden and/or unaddressed, will also affect the rehabilitation and return-to-work strategy. Validated instruments to screen for mental ill-health in the client population are readily available; they should be used when a problem is suspected. This would require clear guidelines for the caseworker on *i)* when to consider using such instrument; *ii)* what to do when a mental health problem has been identified (*e.g.* who to refer to); and *iii)* how to handle confidentiality issues (*e.g.* what to do if the client is not accepting to address any upcoming problem).
- *Make clients with a mental disorder a target group.* The large share of job centre clients with a mental disorder calls for stronger emphasis on this group, if overall outcomes are to be improved. This could be done through particular national or regional targets for this clientele, which will lead to a more systematic approach. The regional labour market authority should also give this group priority in its role as supervisor of municipal job centres and should help smaller job centres in handling the issue. Caseworkers need to have access to the tools available to help this target group.
- *Intervene earlier for those with a mental health problem.* For jobseekers with a mental disorder, earlier intervention is needed. Current regulations according to which insured unemployed aged

30-59 will not receive any support in the first nine months of unemployment are counterproductive for this group and those with repeat unemployment spells in particular. This suggests screening tools will have to be applied earlier and co-operation is needed with the unemployment insurance funds to prevent clients with a mental disorder from falling through the crack.

Upgrade resources for clients with a mental health problem

- *Invest in low caseloads and psychological training for caseworkers.* Jobseekers with a mental disorder need to see their caseworker frequently, and they benefit hugely from their caseworker's psychological knowledge. Services operating with a caseload of around 20 jobseekers and with psychologically trained caseworkers have been shown to yield very good results. Budgetary constraints in mind, this will be the direction to go.

- *Put more focus on health-targeted measures*. Job centres can involve external expertise and outside psychologists, and can recommend the use of proven therapies (such as cognitive behavioural therapy, for example). However, there is ample potential to *i)* expand the use of health-targeted measures, *ii)* improve the co-operation with the health sector and *iii)* better involve doctors at different stages of the return-to-work process; thereby strengthening treatment prescription and treatment compliance monitoring.

- *Focus on the unemployed moving onto sickness benefit.* There are various groups which are at a particularly high risk of long-term labour force withdrawal caused or aggravated by a mental disorder. One of these groups which should receive particular attention is people who move from unemployment benefit to sickness benefit – a group which includes an exceptionally high share of people with a mental disorder (as confirmed by data for other countries) and shows a poor return-to-work performance. This group of clients should be accompanied and followed-up very closely.

- *Focus on social assistance clients at high risk of moving onto disability benefit.* Another high-risk group is recipients of social assistance benefits with a mental disorder who are frequently parked on welfare before claiming a disability benefit. Social assistance clients are receiving more attention today (by being considered as match group 2), but the high and increasing risk of a transfer onto disability benefit can only be halted by stronger and earlier

casework and follow-up and frequent use of work trials, and it will probably require a lower caseload.

Implement ongoing reforms swiftly and rigorously

- *Closely monitor the reform of the flexjob scheme*. The forthcoming reform of the Danish flexjob scheme has considerable potential because, for the first time, some critical weaknesses in its design (including its unique generosity) are being tackled. Nevertheless, the success of the reform will hinge on its implementation. Whether the more temporary nature of flexjobs will lead to any outflow into non-subsidised employment, for example, remains to be seen. Five years seems far too long for an initial entitlement. Similarly, it is too early to tell what the consequence of the new flexibility of the scheme (allowing between one and 39 weekly hours of work) will be; judging from the past, there still is a high risk that the scheme will attract the wrong people (*i.e.* people able to work without a wage subsidy) with no effect on the disability benefit caseload.
- *Reform of the reimbursement mechanism.* At this stage, the details of the reform in the way municipalities will be reimbursed by central government funds for their spending on employment supports and benefit payments are not fully known. The plan to move to a system that is dependent on the client's duration in the benefit system is promising in principle, especially for clients with more complex problems who are least likely to be helped by the current system. In the future it will be more difficult for the municipalities to play the system. However, the actual consequences are unknown and will need to be evaluated rigorously.

Notes

1. The three main ALMPs offered in Denmark are *i) guidance and upgrading of skills and qualifications* (a low-threshold measure normally used for up to six weeks unless more complex education needs are identified); *ii) practical work training in enterprises* (targeting the hard-to-place unemployed who are not immediately job-ready typically for 4-26 weeks according to needs); and *iii) wage subsidies* (targeting longer-term unemployed who are almost job-ready but needing help; the subsidies can last for up to one year).
2. Søgaard and Bech (2010) conclude a validated screening instrument could be used by the municipal services, and clients showing a test result indicating a mental disorder should be sent to a doctor for a psychiatric examination.

3. If the workability record of a client receiving a sickness benefit would state that the person will not get work-ready before, say, three years, the client would be shifted from sickness benefit onto social assistance – the implications of such a shift depending on the priorities of the job centre.

4. Only in 2007, when municipal job centres became fully responsible for all employment policy matters, was municipal co-funding for unemployment benefits introduced; before 2007, this benefit was state-funded (through the unemployment funds which are administered by the social partners).

5. There is no parliamentary agreement on this yet but the duration principle seems to be largely agreed and also supported by the municipalities. However, not only have the parameters yet to be set; there is also an ongoing discussion on how to adjust for local disadvantage, i.e. across municipalities.

6. These caseloads refer to one particular job centre, but the numbers are likely to be indicative of the situation in job centres more generally.

7. The largest benefit category, disability benefit, is not shown in Figure 4.3 because disability benefit in Denmark is a *permanent* payment, *i.e.* close to 100% are still on disability benefit a year later.

8. Currently, a flexjob subsidy can be paid at two levels: at 50% of the person's actual wage for people with 50% capacity and at 67% for those with 33% capacity. There has been a gradual shift over time towards 67% subsidies.

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Chapter 5

Tackling labour market exit in Denmark due to disability benefit

This chapter looks at the role and functioning of the Danish disability benefit system, the pathway through which people leave the labour market permanently, due to reasons of disability and mental ill-health. It discusses why the system, despite a large number of reforms over the past decade, continues to draw so many people into inactivity; and what was needed to change this. The chapter has a particular focus on assessment and reassessment aspects, and reflects on the potential of forthcoming reform.

Disability benefit in Denmark is seen as the last step for people unable to work in either a regular or a subsidised job (*i.e.* a flexjob). However, this way of thinking is not reflected in the actual outcomes: both the annual number of new claims and the disability benefit caseload are still very high compared with other OECD countries (Figure 1.1 and OECD, 2010), many of which are now trying to restrict disability benefits to those permanently and fully unable to work. This is despite Denmark having undergone a comprehensive disability benefit reform back in 2003, when partial disability benefits were abolished and an innovative eligibility assessment tool was introduced. The recognised failure of this reform is about to lead to another series of important changes, including the above-discussed reform of the flexjob scheme and the new rehabilitation approach for people under age 40 leading to much tighter access to disability benefit for young adults. The impact of these and other promising reforms, discussed below, remains to be seen.

The population claiming disability benefit is changing

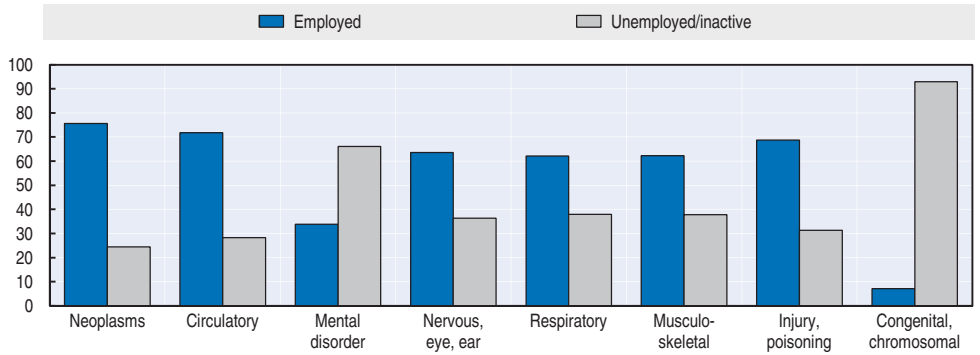
In the past 20 years, the composition of disability claims has changed in Denmark, as in many other OECD countries. The typical new claimant is more often female, younger on average than previously, and in particular (and related to both the age and the gender dimension) more often suffering from a mental disorder (Figure 1.3). The gradual shift towards mental disorders becoming the main cause for a new disability benefit claim suggests that the system and the many reforms of it failed to address the particular challenges of this claimant group.[1]

OECD (2012) concludes that the universal shift across all OECD countries towards disability benefit being caused by mental disorders – without a corresponding increase in the prevalence of mental disorders in the population – is the result of a combination of factors, including a better identification of often co-morbid mental conditions and a more disabling interpretation of such conditions, as reflected in higher shares of full and permanent benefit grants and a lower likelihood of benefit denial for this group.

Claimants with a mental disorder are much further away from the labour market at the moment of their claim. Data for Denmark show this phenomenon clearly. Two in three new disability benefit claimants with a mental disorder were unemployed or inactive in the past five years prior to claiming the benefit – in contrast to claimants with other types of illnesses and disabilities (except for congenital and chromosomal disabilities), the majority of whom were employed in the past five years (Figure 5.1).

Figure 5.1. **Most disability benefit claimants with a mental disorder were out of work for a long time**

Proportion employed and not employed in the five years prior to a disability benefit claim, by health condition, 2009

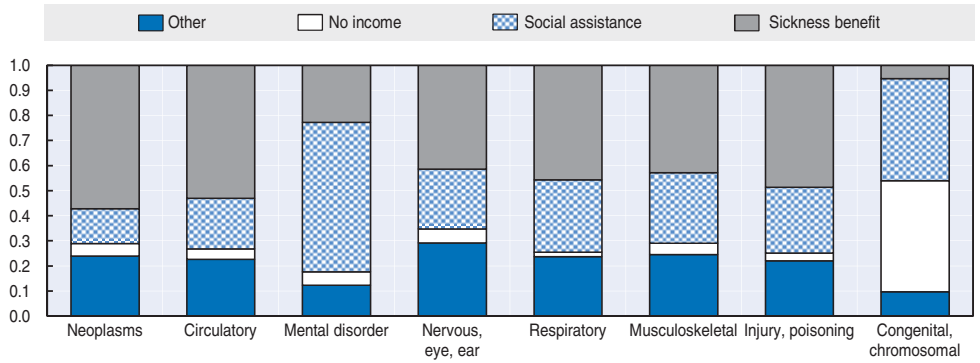


Source: Data provided by the National Social Appeals Board.

Data on previous income and benefit status substantiate this finding. Some 60% of all new claimants with a mental disorder have received social assistance payments prior to claiming disability benefit and only some 20% a sickness benefit, with these shares being roughly the opposite for claimants with other health conditions (Figure 5.2).

Figure 5.2. **People with a mental disorder often claim disability benefit via social assistance**

Distribution of new disability benefit claimants by previous benefit and income status (in %), by health condition, 2009



Source: Data provided by the National Social Appeals Board.

In order to reduce the number of new disability benefit claims with a mental disorder and raise the number of people retaining their job or returning to employment, a four-fold strategy is needed consisting of: *i)* early intervention when (and if) those people are still in employment; *ii)* much stronger emphasis on the mental health barriers of the long-term unemployed and those on the social assistance caseload; *iii)* better means to identify the workability and the resulting support needs of those close to claiming a disability benefit; and *iv)* better supports for those on disability benefit already to help them move back into employment and possibly off disability benefit. The first two aspects are tackled in earlier parts of this report; the latter two are discussed in more depth in the following.

Seeking the best way to assess disability benefit eligibility

With the 2003 disability benefit reform, an entirely new assessment approach was introduced reflecting a move from assessing a person's incapacity to assessing his or her capacity: workability of those applying for a benefit is now determined through a *resource profile* which is filled out together with a caseworker and describes the patient's resources and barriers, and benefit eligibility is tested against the ability of the person to perform a subsidised flexjob. The twelve components of the resource profile concern: the person's *i)* education and skills; *ii)* labour market experience; *iii)* interests; *iv)* social competence; *v)* re-adjustment ability; *vi)* learning ability; *vii)* job preferences; *viii)* performance expectations; *ix)* work identity; *x)* dwelling and finances; *xi)* social network; and *xii)* health. Hence, health is only one of the twelve components while three other components (*iv*-*vi*) refer to the person's cognitive and mental fitness.[2]

OECD (2010) characterised the new Danish eligibility assessment which has now been operating for almost a decade as good practice in principle, with its strong emphasis on ability rather than disability, and a possible way forward for other countries. However, the tool is now seen as a failure because the resource profiles were never implemented as intended.

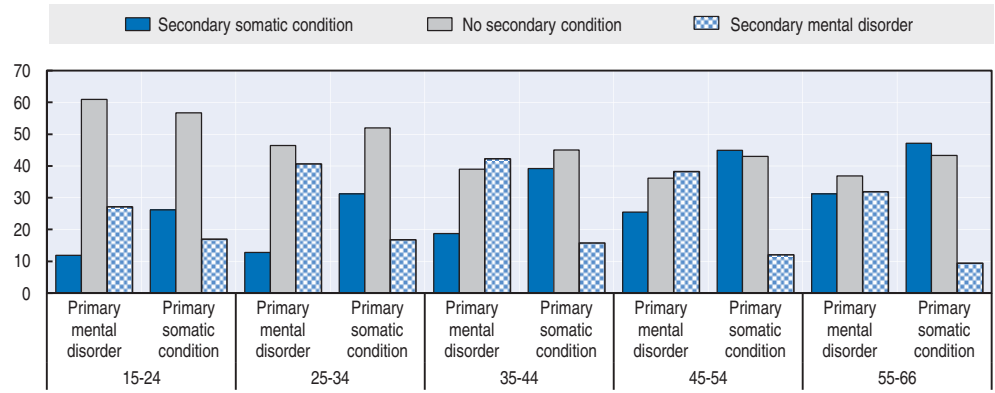
Why has this happened? It appears that the resource profile was too comprehensive and too ambitious, with a lack of guidelines and training for the caseworkers and social security doctors applying the profile on how to do so and unclear rules on documentation. After all, in practice the resource profile has not been used as a tool to develop workability but as a tool to demonstrate incapacity and eligibility for a disability benefit or, in the best case, a highly subsidised flexjob. Moreover, although three components of the resource profile relate to mental fitness, the tool was least effective for those with a mental disorder: for example, most of the trial work used to establish the claimant's work capacity is focussed on physical disability.

With its new approach, Denmark tried to get (treating) doctors out of the system and let caseworkers decide if the available evidence is sufficient for a decision or if medical clarification was required. However, it appears that in regard to mental disorders the decision continued to be based predominantly on the medical file in most cases. It is unclear whether the involvement of more specialist doctors (i.e. psychiatrists) would have made a difference.

In short, it appears that the resource profile, albeit well-intended, failed because of its complexity and an impossibility to be implemented properly. This is likely to be related to the complexity of the impairments and the resulting obstacles claimants are facing; claimants with a mental disorder in particular. For example, a large share of such claimants are confronted with additional co-morbid conditions; especially often a secondary mental disorder (Figure 5.3). Generally speaking co-morbidity increases with age.

Figure 5.3. **Co-morbid conditions are frequent, especially among older workers**

New disability benefit claims by primary and secondary health condition: share with only one condition and with a co-existing mental disorder or somatic condition, 2009



Source: Data provided by the National Social Appeals Board.

Testing a new workability assessment tool

From 2010 to 2012, Denmark was running a big return-to-work (RTW) trial programme. The overall goal of the trial was to contribute to reducing sickness absence duration and improving health, workability and RTW of the long-term sick. As part of this comprehensive trial, a simple RTW interview and workability assessment tool is being used, with a strong focus on uncovering resources and barriers to a return to work. The tool is being combined with the establishment of multidisciplinary RTW teams which should deliver an agreed and consistent work-capacity decision at a much earlier stage; see Box 5.1 and Aust et al. (2012) for more details.

Box 5.1. **Developing an effective workability assessment tool**

The current RTW trial is costing EUR 40 million; running in 22 municipalities throughout the country; reaching around 19 000 people in total; and building on the conclusions of two recent White Papers on the elements of a successful RTW (NRCWE, 2008 and 2010). The following are key components of the workability assessment tool used in the trial.

First step is a one-hour initial interview by the RTW coordinator (a sickness benefit officer) with a long-term sick-listed person placed in match group 2, including a mapping of the employment situation and a screening to identify the support needs (beyond help the caseworker can provide directly) and the need for a more in-depth assessment by a psychiatrist.

Where in-depth assessment is required, multi-disciplinary conferences are held involving the municipal caseworker, an occupational therapist, a psychologist and a psychiatrist. Instead of taking several months, the trial aims at a very tight intervention schedule reducing substantially the waiting time for the assessment by different professionals. The multidisciplinary RTW teams enable closer cooperation between municipal officers and health professionals. The multidisciplinary meetings seek agreement on the number of hours the person can work; on when he can return to work; and on what accommodation is needed.

The process is managed by the job centre. The municipality must establish an appropriate number of RTW teams (depending on population size), with each team consisting of two RTW coordinators (municipal sickness benefit caseworkers), a psychologist, a physiotherapist, a psychiatrist and a physician (specialised in occupational, social or general medicine). Doctors are involved and reimbursed for their time through a contract with the municipality.

The aim of the RTW assessment tool is to find out what tasks the person can do and to explore the links with the workplace, the work motivation and the thinking about how well one has to be to return to work. In case of low work or RTW motivation, for example, the person will be referred to a psychologist. If workplace issues or conflicts are involved, the RTW coordinator has to contact the employer.

The success of the new tool hinges on the ability of all those involved to fulfil their roles. A targeted three-week training course has been offered for the involved caseworkers, psychologists and physiotherapists. Psychiatrists and physicians have participated in parts of the training course. Every expert is asked to be clear and simple: they have to produce up to but no more than 1.5 pages of information about the client to make information accessible for the other experts. The aim is to agree on the best possible RTW plan for each sick-listed person as early as possible. Another expectation is that a multidisciplinary team will be less afraid of addressing mental health issues.

A note is being sent to the client's general practitioner (GP) telling him who is involved and including some feedback (e.g. information about a client's depression). When necessary, the municipal caseworker or another member of the multidisciplinary RTW team has to contact the GP.

Before the start of the trial it was expected that 50% of the clientele in the trial can be handled by the caseworker while the remaining 50% will need a more collaborative effort. Screening always includes the use of a mental health instrument validated on people on long-term sick leave; and according to the initial results, one in two clients have a mental health problem, often co-existing with other health problems (*e.g.* one in three with a musculoskeletal problem has a major mental health problem).

An interpretative manual is also available for the RTW coordinator, including information on answers (*e.g.* around pain and fears) that are alarming from a mental health perspective. Identifying mental health problems earlier means that more issues will have to be addressed earlier. Ultimately, this may lead to longer absence periods initially, in exchange for a reduced risk of both very long-term absence and permanent labour market exit via disability benefits.

Findings from the just released evaluation suggest that the new RTW approach could result in positive effects on sickness absence duration and RTW among beneficiaries, provided municipalities make sufficient effort to implement the entire programme comprehensively: action must be taken early, in a multidisciplinary and coordinated way and directed towards the workplace (NRCWE, 2012). Some 60% of the municipalities participating in the RTW trial succeeded in implementing the programme successfully, but outcomes varied considerably also across successful municipalities. Overall, effects on RTW were more moderate in size (and statistically not always significant) than effects on sickness absence duration; in successful municipalities the latter fell by an average of 2.6 weeks.

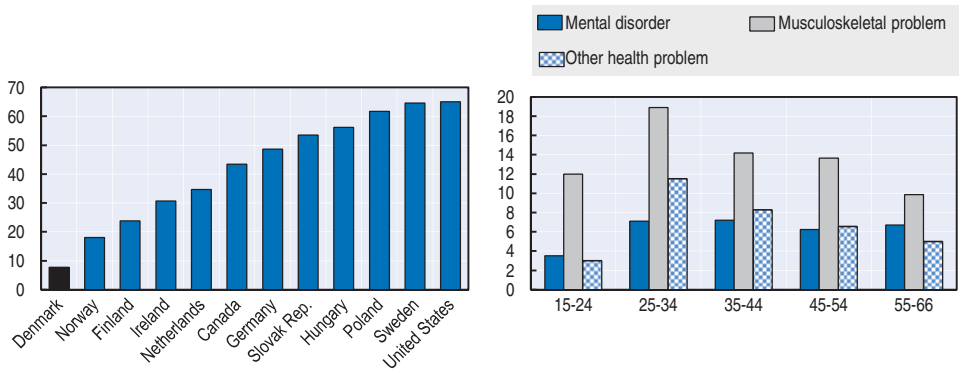
Towards reassessment and benefit outflow

One problem in Denmark is that disability benefits are always granted permanently: outflow from disability benefit is practically zero, and lower than in any other OECD country (see OECD, 2010: typically benefit outflow is around 1-2% of the caseload annually – which is also low but much higher than in Denmark). This is in contradiction to research showing that 50-80% of even severe mental disorders improve over time, and survey findings for Denmark according to which 50% of all disability benefit recipients claim to be in good health and 20% say they want a job.

Despite negligible outflow, Denmark also has the lowest disability benefit rejection rate in the entire OECD. With the exception of the Nordic countries, across the OECD between one-third and two-thirds of all applications are rejected; the corresponding proportion in Denmark is only 8% (Figure 5.4, Panel A). For claims with a mental disorder, the rejection rate is even lower, especially among those under age 25 (Panel B).

Figure 5.4. **Disability benefit claims in Denmark are rarely rejected**

Proportion of rejected disability benefit claims in all new disability benefit claims



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

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

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

Source: OECD calculations based on the OECD questionnaires on disability and mental health.

Partly the high benefit approval rate in Denmark is a result of the benefit application process: the majority of new claims are recommended by the job centre caseworker. The use of the resource profile by which the job centre can assess the person's workability and the potential to improve that ability through rehabilitation, activation or other measures would typically *precede* the recommendation for a disability benefit claim. Other countries also have a mix of administratively recommended and direct individual applications for a disability benefit but the one-stop nature of the job centre implies better knowledge by the administration of potential benefit eligibility.

Together, negligible benefit outflow and the low rejection rate account for a considerable part of the comparatively high disability benefit caseload and the continuously high number of new benefit claims in Denmark, and also some of the very high share of claims with a mental disorder. The combination of low rejection and lack of reassessment, especially for those with a mental disorder, implies that it is easier to get onto disability benefit and that those who see their health condition and workability improving

over time will remain unnoticed and excluded from the labour market and possible employment support.

Other countries have solved this general challenge of disability policy – to find a balance between tightening access on the one hand and securing social protection on the other – in a very different way: first, by being much stricter in inflows; and secondly, by reassessing entitlements more or less rigorously at regular intervals. The new assessment in the Danish RTW trial with its particular focus on mental disorders could go some way to address the first issue (if implemented more widely), but the second issue remains unaddressed. Other countries, *e.g.* the United Kingdom and the Netherlands, have decided to reassess benefit entitlements of current recipients in line with newly introduced eligibility criteria – resulting in large numbers of benefit losers, especially among those with a mental disorder.[3]

Such reassessments of existing entitlements could also be considered in Denmark – given the high caseload and the development of new assessment and support tools. Legally, reassessment is possible but it is only done currently at the recipient's request. Moreover, the current regulation implies that the municipality would have to prove an improvement in the beneficiary's circumstances; hence, changes in assessment and eligibility criteria alone do not justify a loss in entitlements. The government has chosen to avoid reassessments altogether, largely for political reasons. Other countries, like Australia, have also often opted for grandfathering those on benefits to make reform possible. But the examples of the Netherlands and the United Kingdom show that many of the longer-term beneficiaries have considerable work capacity; countries with a large beneficiary caseload should not exclude this group from reform.

The aims of the forthcoming disability benefit reform

Instead of reassessing entitlements, with the forthcoming disability benefit reform Denmark has chosen to offer new opportunities for those on benefit. They will become eligible for support from the job centre on a voluntary basis, while keeping their benefit – provided the municipality concludes the person can benefit from such support.

Experience from other countries – including, for example, Sweden – suggests that the take-up of such voluntary options is likely to be very low. By way of example, the job centre in Roskilde tried to reactivate disability benefit recipients with a similar voluntary approach already back in 2002 – with no success. Given the multiple problems (including health problems) many of those who have received disability benefit for a long time have, or have developed, additional resources would be necessary to make it more

likely for those voluntarily participating in job centre measures to be able to move into employment (and at the same time, ideally, off benefit).

Other forthcoming changes, such as a stronger focus on integrated rehabilitation, will only affect those being granted a *new* disability benefit (Chapter 2). Changes will also include minor adjustments of benefit payment rates, including lower benefits for those living abroad and greater consistency between actual need and the level of extra-cost benefit top-ups. Otherwise, the generous disability benefit payment levels remain untouched, for both current and new recipients. OECD (2010) has shown that the net replacement rates from disability benefit in Denmark are among the highest in the OECD: around 80% for an average-wage earner, and as high as 115% for a low-wage earner – and thus some 10-20% higher than the payment rates for unemployment and social assistance benefit.[4] If beneficiaries take up work, some 70% of their earnings are "taxed away". This generosity will continue to provide a considerable incentive to apply for a disability benefit and a disincentive to seek work; this could counteract the intentions of ongoing reforms – including the reform of the flexjob scheme – which aim to reduce both the disability benefit caseload and the number of new claims.

Conclusions and recommendations

Disability benefit in Denmark aims to provide a security net for people with a range of health and social problems who are unable to work even in a subsidised job. Thus defined, very few people should qualify for a disability benefit. In practice, however, the number of new claims is very high, the majority of people claiming with a mental disorder. A high benefit approval rate and the lack of any entitlement reassessment contribute to this outcome, with disability benefit continuing to be a relatively accessible permanent payment. These rules will have to be reconsidered.

Assessment is critical for determining benefit inflow and outflow. Back in 2003, Denmark went through a comprehensive and innovative reform of its approach to assessing entitlement for disability benefit. However, the system which is based on a person's resource profile failed because it was too ambitious and complex, while giving little guidance on how it should be implemented. Learning from the past, another overhaul of the assessment system is in the pipeline, building on the elements of the existing scheme but removing its weaknesses: seeking early agreed decisions by all involved systems, and following a very prescriptive and relatively simple process. It is very early days, but results from initial trials are promising.

The changes are especially critical in view of the large number of claimants with a mental disorder: claimants who on average are much further away from the labour market and access disability benefit after a

period on social assistance payments. For them, the current approach seems especially inadequate and so is the fact that payments are permanent – in view of the good recovery potential for many clients with mental ill-health and the disastrous impact of unemployment and inactivity for this group in particular. Any new assessment approach will have to pay particular attention to the way it affects those with a mental disorder.

Seek ways to reduce the number of new disability claims

- *Apply lessons from the recent RTW trial*. The trialled assessment tool includes a range of promising changes. The approach differs considerably from the current one, implying a lot of change for many actors and institutions. Functioning of any new assessment requires two elements: first, everyone involved needs to understand his/her role and the need for urgent action; secondly, appropriate incentives, good training and clear guidelines (on what to do when) need to be put in place for those involved. The non-involvement of GPs is a potential weakness which needs reconsideration.
- *Extend the rehabilitation model beyond age 40*. The forthcoming rehabilitation model for those younger than age 40 has strong potential, especially through its integration of employment and health services, to raise labour force participation and prevent disability benefit claims. Once the model is up and running for those under age 40 and has demonstrated its merit, it should gradually be extended to all age groups. There is no reason for limiting a better approach to people under age 40.

Move towards regular entitlement reassessment

- *Reassess new entitlements systematically*. Very few people, much fewer than is the case in Denmark today, have a health condition that justifies a permanent disability benefit. The Danish approach of accepting almost everyone who applies for a disability benefit and at the same time shying away from reassessing claims periodically is costly and fostering exclusion. Instead, entitlements should be reassessed regularly after a predefined period; especially when the practice of granting a disability benefit remains unchanged.
- *Consider reassessing current entitlements*. Current disability beneficiaries will be entitled to supports from the job centre on a voluntary basis. In view of the high beneficiary caseload, limited effectiveness of voluntary supports, and fairness considerations, a tighter approach should be considered. Some countries have chosen to reassess their caseload in line with newly introduced assessment

criteria and Denmark should do likewise, while providing sufficient employment support to people losing their entitlement.

- *Monitor the impact of the high benefit level*. The high level of disability benefit especially for low-wage earners could offset reform intentions. This should be monitored closely and payment levels reduced if reforms continue to be ineffective.

Notes

1. After a continuous increase over the past three decades or so in the share of claimants with a mental disorder in all new disability benefit claims, this share has unexpectedly fallen slightly in Denmark over the past two years (2010 and 2011). It is too early to tell whether this is a turnaround in the trend increase or only a temporary phenomenon, maybe caused by the sharp hike in unemployment in the course of the financial crisis.

2 . This implies that it is possible in Denmark to qualify for a disability benefit as a consequence of a range of personal, social and other problems without the health component itself being affected. This is exceptional in an OECD comparison, with disability benefit entitlement in other countries generally requiring significant chronic or long-lasting health impairment.

3. In the United Kingdom, for example, the *entire* incapacity benefit caseload is currently being reassessed according to new work capability criteria. As a result, many people including some who have been on such benefit for a long time are losing their entitlement: broadly speaking, around one-third is found fit-to-work and taken off benefit; one-third is judged as able to do some work with extra support; and only one-third is eligible for unconditional continuation of their payment. Among those with a mental disorder, the latter group is particularly small.

4. This finding is based on a special module of the OECD tax-benefit model available for ten OECD countries, which includes cash incomes (including all types of benefit income), income taxes and, where applicable, social security contributions. Synthetic benefit replacement rates are calculated for a 40-year old person with a full earnings history since age 18 and are unweighted averages over six family types.

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Chapter 6

The interface between the health and the employment systems

This chapter discusses the effectiveness of the mental health care system in Denmark in providing adequate treatment to persons with common 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 reviews the links between general and specialist care and recent policy initiatives to improve co-ordination between, and integration of, the mental health care system and the employment system.

Most mental illnesses have good potential for improvement over time if treated quickly and effectively. Adequate treatment is, therefore, essential in any policy strategy aiming to raise the labour market participation of people with a mental disorder which is often chronic. But there are problems with the availability and accessibility of treatment, as well as its adequacy and quality.[1] There are also challenges around linking general health care with specialist psychiatric health care. Maybe the biggest problem is the lack of integration of care and treatment on the one side and rehabilitation and employment services on the other, with responsibilities in the hands of different authorities (the five regions for health services and the 98 municipalities for social and employment services) and with the mental health system being slow in adopting its employment responsibility. These challenges are addressed below.

Identifying and tackling the treatment gap

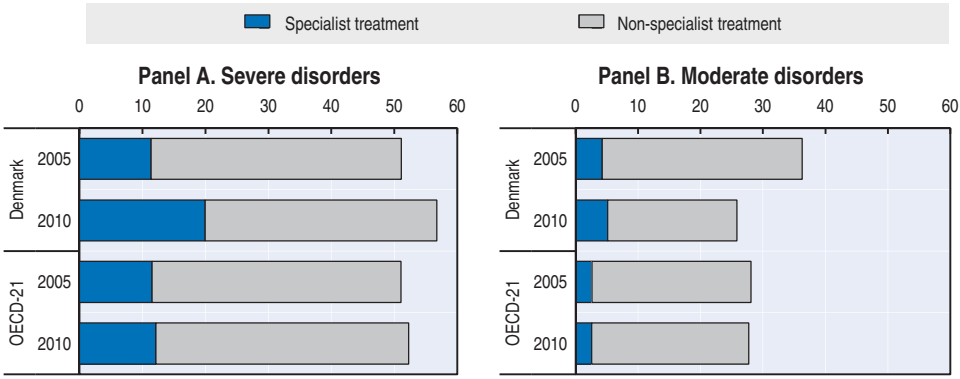
Is the Danish mental health system treating everyone who needs treatment and in the best possible way? It is impossible to answer this question, because not everyone needs treatment or the same type and intensity of it, and because treatment and medicalisation of a milder mental disorder can also make things worse, especially for young people. Hence, data on treatment intensity need to be interpreted very carefully.

Evidence on the share of persons who sought treatment for their mental illness, based on data from the Eurobarometer, suggests that *i)* around half of all Danes with a severe mental disorder have sought treatment in the past three months, and around one-third of those with a moderate disorder; and, similarly *ii*) non-specialist treatment in general practice accounts for half of all treatments for people with a severe mental disorder and for almost two-thirds for those with a moderate disorder (Figure 6.1).[2]

Hence, under-treatment is potentially very large and remains a big concern in Denmark, as in other countries. Non-treatment is not equivalent to unmet need but it is a good proxy for it. A large-scale European study, for example, concluded that half of those with mental health care needs have unmet needs, corresponding to one-quarter of the population identified as having a 12-month mental disorder (Alonso *et al.*, 2007). The reasons for underuse of mental health services are manifold, including personal reasons to do with self-stigma and non-recognition of needs on the one hand and mental health system issues on the other. The latter can include insufficient service provision as well as problems with access to and effectiveness of treatment.

Figure 6.1. **Moderate mental disorders are rarely treated and if so only by generalists**

Share of people who sought treatment for their mental illness in the past three months, by severity of the disorder and type of treatment, Denmark versus EU-21, 2005



Source: OECD calculations based on Eurobarometer 2005.

There is a significant shortage of psychiatrists in many parts of Denmark and consequently significant waiting lists for psychiatric services.[3] For example, there are only 125 practicing psychiatrists across the country for around 50 000 patients every year (implying an annual average caseload of around 400 patients). Another 90 000 patients each year are treated in psychotherapy clinics, which offer evidence-based treatment for common mental disorders, especially cognitive behavioural (group) therapy. Hospitals have around 45 000 stationary psychiatric inpatients and some 75 000 ambulant outpatients every year (data for 2009). Private practices, hospitals and psychotherapy clinics taken together, there are some 700-800 psychiatrists in Denmark. As a consequence, specialised psychiatric nurses, social workers and psychologists in addition to general practitioners (GPs) carry a significant weight of the Danish mental health care system.

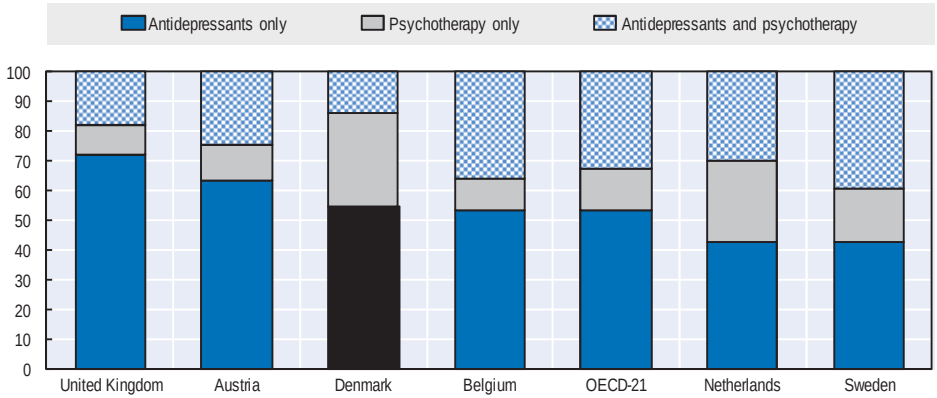
Increasing psychiatric capacity in line with rising demand has proven difficult. Apparently there are vacant positions in many parts of the country, for psychiatrists as well as specialised nurses. Recruitment problems partly arise because of stigma within the health field, with psychiatry considered as a non-scientific field and mental illnesses regarded as "difficult" illnesses. There is a continuous need for more psychiatric capacity at all levels – more psychiatrists, more community mental health care services, also more hospital beds maybe – but also for more specialisation *within* the field of psychiatry (similar to the one centre in Denmark, for example, which is highly specialised in dealing with eating disorders).

Formally, there is a treatment guarantee of two months for all mental health services – compared to one month for somatic illnesses. The guarantee has reduced average waiting times successfully in some cases; *e.g.* for eating disorders (which mainly affect young people and especially young women) the average waiting time was reduced from one year to 1-2 months.[4] However, waiting times remain too high in many cases, with significant differences across regions. One reason for long waiting times is the need for a diagnosis in the social system using up a considerable share of the limited available psychiatric resources urgently needed for treatment. Another reason is that some 90% of all inpatient hospital referrals for adults are acute cases, leaving limited room for the treatment of chronic mental disorders and implying longer waiting times for people with mild and moderate mental disorders in need of hospital services.

Eurobarometer data also show that medication is the dominant form of treatment in all OECD countries, including Denmark (Figure 6.2).

Figure 6.2. **Only few Danes receive combined medication and therapy treatment**

Share of people in treatment[a] by nature of their treatment, 2005



Note: OECD-21 is an unweighted average.

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

Source: OECD calculations based on Eurobarometer 2005.

Denmark is somewhat exceptional in so far as combined therapy *and* medication treatment is rare: of those receiving a therapy, only one-third receive medication as well. In other countries the opposite seems to be the case. It is unclear how this might relate to the peculiarities of the Danish system. As in other countries, guidelines on treatment for mental disorders

exist, prepared by the National Board of Health (NBH) which is responsible for authorising health personnel.

The pressures on non-specialised mental health care providers

The lack of sufficient psychiatric capacity is putting considerable pressure on all other parts of the Danish (mental) health care system. Social workers, for example, either working in a municipality or employed by a hospital, have become key actors in the mental health field: as the point of contact with the people, with the social system and the municipal job centre caseworker, and with the employer.

As in other countries, a large weight is carried by the GP who acts as gatekeeper to the specialist mental health care system but also provides initial or the only treatment for most patients. Mental health knowledge of GPs is therefore critical. Denmark has been quite successful in educating GPs on this score: most of them have taken e-training about stress, anxiety and depression, about how patients can remain at work and how the GP can support this – training offered to enable them to fill in appropriately the recently introduced record of workability that indicates whether a patient is fit for work (Chapter 3). GPs are reimbursed for compiling these records, and they are also reimbursed for participating in meetings with the patient's employer, if necessary.

GPs in Denmark are also important providers of talking therapy. Some 80% of them provide psychotherapy sessions to patients with mental illness. GPs are reimbursed for seven sessions of conversational therapy and the number of psychotherapy sessions given by GPs has increased from 265 000 in 2007 to 335 000 in 2010. GPs can also refer their patients to one of the many psychologists available in the country. The latter are important mental health service providers although predominantly operating outside the health system, at least until recently. There are about 800 university-trained psychologists in Denmark with a contract with the region but a much larger number otherwise, largely paid by the individual seeking psychological service or therapy. Reimbursement for treatment by an authorised psychologist is 60% of the cost. Since 2008, people under the age of 37 with light to moderate depression can get psychological therapy fully reimbursed by the health system – the age limit being determined by the budget. From 2013 onwards, patients of all age groups will qualify for such reimbursement; this is a promising step because evidence shows that Danes otherwise used to having access to free health care tend to be reluctant to pay for psychotherapy themselves.

Connecting general and specialist health care

There is an evident gap in Denmark in regard to the connection of specialist health care – provided by psychiatrists, psychotherapy clinics and hospitals – with general health services, especially general practice. "Shared care" involving both specialised psychiatric and primary care is recommended but largely unavailable in most parts of the country. The idea of shared care is to create closer co-operation through an increased level of communication, better utilisation of specialised care and a rationalisation of resources through a co-ordinated effort in the hospital sector, the general practice sector and the municipal sector. The central government allocated DKK 100 million in 2012 to projects aimed to develop shared care models.

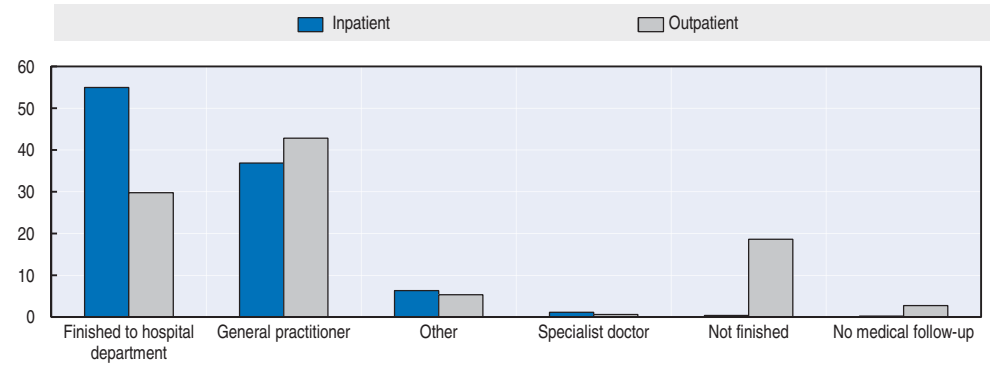
Similarly, a stepped mental health care approach from low-key to intense intervention, starting in the workplace and ending with psychiatric hospitalisation, is not sufficiently developed. In reality, steps are often too high and a stepped care case manager (for example, a psychiatric nurse) is lacking. Another underdeveloped model is teamwork between psychologists and GPs. Co-operation between psychologists and psychiatrists is not possible because psychiatrists cannot refer their patients to a psychologist.

More generally, more could be done to better support the transition from general to specialised care, and back to general care, and especially from the hospital sector to general practice. Discharge from a hospital is a very critical moment for patients, particularly in Denmark because of a relatively short duration of hospital-based treatment (*e.g.* around 20 days on average for affective disorders and ten days for neurotic disorders).

Regions have to have a follow-up plan for those released from a hospital with a more severe illness but not otherwise. The patient's GP can be informed but GPs cannot contact discharged patients proactively. The municipality is in charge of following up a person after hospital discharge as regards its own responsibility, *i.e.* rehabilitation outside of hospitals. Community-based psychiatric units could also take care of those discharged. Little is known on how this is handled. Administrative data suggest that overall around one-third of all inpatients and a little over 40% of all outpatients are discharged to a GP, while discharges to a specialist doctor are rare (Figure 6.3). Similarly, very few people are referred to a hospital by a specialist doctor; most inpatient referrals come from other hospitals and for outpatient treatment, 40% are referred by their GP.

Figure 6.3. **Around one-third of all hospital patients are discharged to a GP**

Distribution of ended hospitalisations by discharge destination, Denmark, 2009



Source: e-Health Clinical Database (National Institute for Health Data and Disease Control).

Treatment compliance and mental health screening in private practice

Following up patients treated by specialist mental health care is also critical in view of low treatment compliance – which is much lower than for somatic illnesses. In a large-scale follow-up study of patients of Danish psychiatrists in private practice, Munk-Jørgensen and Andersen (2009) find that more than one-quarter of all treatments ended in dropout. Dropout was especially high in younger men, those with shorter treatment durations, users of psychotropic medication and those with a personality disorder.

GP referrals to specialised health care raise the broader issue of recognition of mental illness in private practice. Many patients in private practice will not reveal their mental health problems or, instead, present with a somatic illness. Munk-Jørgensen *et al*. (2006) found that only one-third of all generalised anxiety disorders (GAD) – with a prevalence rate of 5-6% in the study population – would be recognised by the GP.[5] The GAD recognition rate was higher if the patient presented with anxiety problems or had anxiety problems in the past and lower for those presenting with somatic illness. Ostergaard *et al.* (2010) found a GP recognition rate of 55-75% for major depressive episodes (MDE), although 80-90% of those patients were identified as suffering from some mental illness. However, they also found a high rate of 15-25% of false-positive MDE recognitions of people not suffering from MDE. Such findings suggest that a more systematic mental health screening of patients in general practice would have a lot of potential. This would require clear regulations on when and whom to screen and on what to do next if a problem was identified.

In conclusion, the mental health system has many players but lacks a more systematic approach. For a patient, GPs and district psychiatric units are the two main gateways into the mental health system, with referrals to specialist health care through either one of them. For patients experiencing a crisis situation, a third gateway is the acute crisis centre (ACC) which can be accessed through referral by a GP, a district psychiatric unit, a psychologist or a social worker, or self-referral. The ACC offers quick short-term support and counselling for those having a crisis but not needing hospitalisation, and it also provides counselling at home or via telephone.

Towards integrated health and employment services

Maybe the biggest challenge for the Danish system is the lack of integration of social and employment services (which are controlled by the municipalities) and health services (which are controlled by the regions). A first step in this regard is to develop the employment orientation of the mental health system. There is plenty of evidence showing that work is good for mental health in general and moving back to work can improve mental health (OECD, 2012). Consequently, there is a strong case for seeing work as a plank in a broader treatment strategy, more generally and individually for every patient. This is essential at different levels and moments.

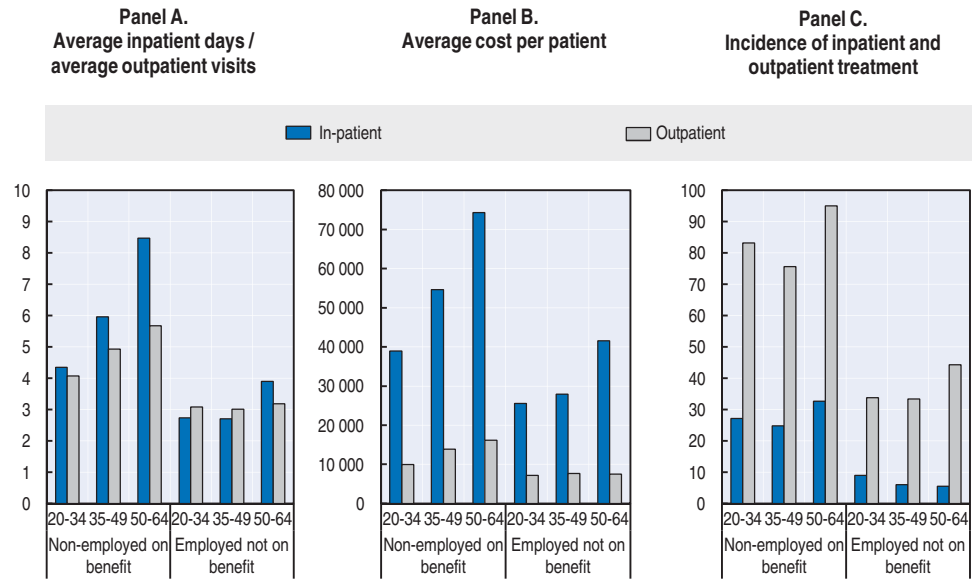
In Denmark, employment is not generally seen as a goal of mental health care: employment is not usually an element in a treatment plan, the focus of which is on care and treatment and proper referral of patients to other parts of the health system; and employment is not an element in the clinical guidelines or in the quality model used in health care. The National Strategy on Psychiatry (published by NBH in 2009), which provides the basis for the development of the mental health sector, also focuses on prevention, cure and access to health services, with no mention of employment. This is related to the division of responsibility for health and employment between the regions and the municipalities. However, the action plan "Enhanced effort for people with mental illness" which builds on the Strategy includes as one of its 29 initiatives "developing measures to keep people with mental disorders in employment or education through support from the municipalities".[6]

A few other OECD countries have gone much further in strengthening the employment orientation and responsibility of the mental health system. The new outcomes framework of England's National Health Service for 2012/13, for example, explicitly includes an indicator on employment of people with mental illness. The Danish health care quality model could include work-related quality indicators as well, as an important first step in moving towards some employment accountability of the health system.

The recent inclusion of employment information in the e-health data system indicates a shift in orientation towards seeing the relevance of employment for health and health system outcomes. So far, however, the data only allow to distinguish health system users by their employment or benefit status but not to follow patients over time to see, for example, to what extent treatment and the type of treatment enables a patient to retain employment or return to employment faster. Available data suggest that those unemployed or inactive and receiving an income-replacement benefit systematically have *i)* much higher incidences of mental-health service use, inpatient as well as outpatient; *ii)* longer average hospital stays; *iii)* more frequent outpatient visits; and *iv)* significantly higher per-patient costs (Figure 6.4). In-patient incidence, for example, is between three times (age 20-34) and six times (age 50-64) higher for those receiving a benefit and outpatient incidence is about three times higher.

Figure 6.4. **Differences in hospital utilisation by employment status are substantial**

Selected inpatient and outpatient treatment indicators by employment status in 2011: incidence of treatment; average cost per patient; and duration of inpatient treatment/number of outpatient visits



Note: The group "non-employed" includes all patients receiving (public or private) social benefits, including unemployment benefit, social assistance, sickness benefit, (pre)rehabilitation benefit, disability benefit and early retirement.

Source: e-Health Clinical Database (National Institute for Health Data and Disease Control).

With the divided health system responsibility, the links between regional and municipal health services are a key concern. Regional-municipal co-operation is addressed through obligatory Health Agreements. The aim of these agreements is to ensure *i)* coherence and co-ordination of effort in the patient pathways that involve hospitals, general practice and municipalities, regardless of the number of contacts or the nature of intervention; *ii)* unique workflows between health care providers; and *iii)* effective communication between all those involved in the individual patient pathway. The agreements, which have to be approved by the National Board of Health, have mental health as one of six focal points. The involvement of employment services is still limited but the focus area on mental health refers to services such as health care, social care, housing, education and employment.

A better connection of the regional health system and the municipal employment and social system is also needed in regard to hospital discharges. Not only is it important to ensure a treatment follow-up for a patient discharged from the hospital, but social, housing and employment needs of this person also need to be followed. Social workers in the municipality need to get as much information as possible to tackle social and housing issues quickly and refer the person to the job centre caseworker if necessary. Today's situation on the contrary is often characterised by a lack of communication in this area.

While health and employment are still two rather distinct fields, some promising projects can be found in Denmark recently. Most noteworthy is a scheme called OPUS targeted at young people in the early phase of a psychosis. This is a programme lasting for 2-5 years, with group sessions, family involvement and treatment (including especially cognitive behavioural therapy). The project's aim is to bring health and employment services closer together, while bridging the privacy issues involved – issues that are often argued to get in the way of better integration of these types of services – by consent. The scheme is run and financed regionally but will have to involve municipal job centres were the scheme rolled-out nationally.

More generally, there are four possibilities for Denmark to improve the integration of health and employment services, possibilities which can also be combined in different ways: *i)* to integrate doctors (GPs and/or specialists) into municipal job centres; *ii)* to integrate employment specialists into general and specialist practices (which is easier in a health system using group practices); *iii)* to develop medical capacity in municipal job centres; and *iv)* to develop employment capacity in the health system.

Recognising the difficulty in better co-ordinating employment and health services, the mental health system in the United Kingdom for

example is recently taking steps to build employment knowledge and employment service capacity into existing and newly offered health services. New so-called "fit-for-work services" and existing but modified occupational health services are empowered to support the patient in job retention and a return to employment in the very early phase of a sickness absence – thereby bridging a service gap. The idea being that users of primary health services get directed easily and quickly to complementary employment services, with health and employment issues (including workplace issues if necessary) tackled at the same time by the same team. Referral to such services is very simple, via the GP or by self-referral (with proactive outreach to inform people about the existence of these services). Something like this could also be considered in Denmark. Municipalities – through co-funding of regional hospital spending – have an intrinsic interest in avoiding hospitalisations of their inhabitants by investing in effective prevention. Regions, on the contrary, lack any incentives to ensure health policies lead to better employment outcomes and thereby lower the costs for the municipality (and for the society more broadly) of inactivity and unemployment and for rehabilitation and employment support.

Conclusions and recommendations

Unmet mental health service needs can only be estimated roughly but the shortage of psychiatric services at all levels of the mental health system is obvious. Currently, according to survey data, some 60% of those with a mental disorder are not seeking and/or getting any treatment. This situation calls for more investments into psychiatric service capacity but also for measures to ensure that non-specialised, first-line health care providers, including GPs especially, are able to fulfil the many roles they have in health service provision for the mentally ill.

Added to this, the connection between general and specialised health care is a concern both in regard to referrals from general to specialised health care, and in regard to the discharges from hospitals and specialised care to municipal care and general practice. Identifying and tackling mental ill-health in general practice and following up on those receiving and ending specialised treatment are both very critical.

The biggest of all challenges for the mental health care system is the disconnection between health and employment and, for that matter, between regional and municipal services. Health care follows aims and principles which are very different from those followed by the municipality and the job centres in particular. The Danish mental health system is only in the early stages of recognising its employment responsibility. Much better integration of health and employment services will be necessary.

Increase mental health service capacity

- *Ensure ready availability of mental health services*. The capacity of the mental health care system continues to be insufficient, with a need for both more psychiatrists and more specialised nurses. In view of a large number of vacancies, capacity increases may not be possible without higher wages for these professions. The goal of capacity expansion should be to further reduce waiting lists, especially for mild/moderate and chronic mental illness and for children and adolescents more generally, and to achieve a treatment guarantee of one month, just like for somatic illnesses.
- *Develop first-line health services*. First-line, non-specialist service is essential for assuring a good mental health care system, in view of high shares of patients seeing primary care providers only. Much-improved mental health knowledge among GPs is vital, including improvements in the reimbursement of psychological treatment and talking time. GPs also need a clear role in monitoring treatment compliance. Psychologists should be encouraged to seek formal authorisation for patients to be able to get any treatment by a psychologist reimbursed by the health system.
- *Mental-health screening in general practice*. With GPs acting as gatekeepers to both the health and the social system, systematic mental health screening in general practice for certain predefined situations would be promising, in view of available well-validated screening tools. Clear guidelines are needed on who and how to screen and what to do next if an illness is identified.

Improve connection between first-line and specialist care

- *Promote shared-care models.* Shared-care models involving primary care and specialised psychiatric care are a good way to better connect different medical professions; such models are still rare in Denmark. Another way to improve links between first-line and specialised services would be to allow referrals from psychiatrists to (authorised) psychologists.
- *Strengthen municipal follow-up after discharge*. The follow-up of patients leaving a hospital should be improved systematically. Follow-up should concern treatment as well as the person's social, housing and employment needs, the first requiring a doctor and the second a social worker. Currently, a regional follow-up plan has to be prepared for those with a severe mental disorder. With the much improved e-Health Database, this obligation could be extended to

moderate and chronic mental disorders also. GPs could also get a role in proactively following up on mild and moderate cases.

Integrate health and employment services

- *Define the employment accountability of the mental health system*. A first step in this direction would be to include employment aspects in clinical guidelines for doctors as well as in the quality model used in health care in Denmark. Fully integrating existing databases (*e.g.* the e-Health Database and the job centre's Jobindsats Database) would be a step forward in better understanding and researching the links between mental health and employment.
- *Integrate health and employment services*. Like most OECD countries, little has been achieved in Denmark so far in terms of integrating health and employment services. There are various ways of doing this which could be tested for effectiveness to identify the most appropriate approaches for the Danish situation. At the very minimum health and employment services need to have better mutual information on what exactly different institutions are doing.
- *Use municipal-regional Health Agreements as a vehicle*. The recent Health Agreements between municipalities and regions will help ensure more coherent and co-ordinated health pathways. A stronger and more explicit focus on employment in those agreements would stimulate the health system to pay more attention to job retention and to provide services which help those mentally ill to return to their jobs or to the workforce faster.

Notes

1. Mental health care in Denmark is integrated into the general health care system. Health care coverage is universal and compulsory. All those registered as residents in Denmark are entitled to public health care which is largely free at the point of use. Around 30% of the population purchase complementary private health insurance to cover out-of-pocket costs for items not fully covered by the public system. Psychological therapies are not usually part of private health insurance although such therapies are hitherto only covered very partially by the health care system.
2. Specialist treatment in this definition includes treatment by psychiatrists or psychologists (and related occupations such as psychotherapists) – the latter being more frequent in Denmark than treatment by a psychiatrist.

3 . The average waiting time in 2011 (2010) for non-acute adult patients was 38 (35) days and for non-acute children and adolescents it was 72 (77) days.

4. There is a free choice of hospital and a right to choose a private hospital if the waiting time for psychiatric treatment exceeds the prescribed period.

5. At one-third, this share was lower than the corresponding share in the other Nordic countries. It was highest in Norway, at 53%.

6. Otherwise employment and health are only being brought closer together indirectly. The focus of the health system on faster treatment and shorter waiting times for psychiatric services will facilitate staying in employment; after all, most psychiatric patients have a job or have had a job until recently.

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